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Promoting equitable health care financing in the African context: Current challenges and future prospects



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Acronyms

ARV	Anti-retroviral
CBHI	Community-based health insurance
DFID	Department for International Development (British bilateral agency)
DRC	Democratic Republic of Congo
GBS	General Budget Support
GDP	Gross Domestic Product
GNI	Gross National Income
HIPC	Heavily Indebted Poor Countries
IFIs	International Financial Institutions
IMF	International Monetary Fund
MHI	Mandatory Health Insurance
MHIS	Mutual Health Insurance Scheme
NGO	Non-governmental organisation
NHA	National Health Accounts
NHI	National Health Insurance
NHIF	National Health Insurance Fund
OOP	Out-of-pocket (payments)
PRSP	Poverty Reduction Strategy Paper
REF	Risk Equalisation Fund
SAP	Structural Adjustment Program
SHI	Social Health Insurance
SSA	Sub-Saharan Africa
SWAp	Sector-Wide Approach
VAT	Value Added Tax
WHO	World Health Organisation

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EXECUTIVE SUMMARY

The issue of appropriate mechanisms for mobilising health care financing resources is once again high on the policy agenda of African governments. The objectives of this paper, commissioned by EQUINET, are to critically evaluate how health services are currently funded, explore recent trends in health care financing and identify lessons from the health care financing experience of African countries. It also considers the implications of this review for policy, advocacy and future research needs.

Current health care financing

At present, the key health care financing patterns in Sub-Saharan Africa are as follows:

- The current level of health care funding from government tax revenue is relatively low in most African countries, particularly in relation to the target of 15% of total government expenditure being devoted to the health sectors agreed to by the African Heads of State in Abuja in 2001. In the majority of countries (about 60%), the health sector share of total government expenditure is below 10%. Achieving the 15% target would reflect government commitment to some degree of health sector prioritisation in expenditure. It does not imply that this level of funding would be adequate to meet national health needs, even at a most basic level.
- There is still a reasonably high level of reliance on donor funding in African countries. Donor funding accounts for over a quarter of total health care funding in about 35% of countries, with 5% of countries having more than half of all health care funding coming from external sources.
- There is limited insurance coverage in African countries, especially in relation to mandatory health insurance. However, community pre-payment schemes have been on the increase in recent years.
- One of the single largest sources of financing is that of out-of-pocket payments, which exceed 25% of total health care expenditure in more than three-quarters of sub-Saharan African countries. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, both non-profit providers (e.g. missions) and for-profit providers (ranging from doctors working in private practice to informal drug sellers and traditional healers).

Recent health care financing developments

There have been a number of important developments in health care financing in African countries in recent years, as summarised below for each financing mechanism.

Tax funding

The availability of adequate tax funding is critical if problems in equitably accessing health care are to be addressed. While it is difficult to increase tax revenue in African countries due to the limited tax base and that it is often not feasible or advisable to increase personal income tax rates any further, improved tax collection systems have contributed to dramatic increases in tax revenue in some cases and the potential for increased corporate taxes should be seriously explored. In addition, another EQUINET report highlights that there are a range of wealth taxes (e.g. taxes on financial transactions flows, luxury airline travel, currency exchanges) that should be considered. There has been growing advocacy for an increased share of government budgets for the health sector. One of the main constraints to achieving the Abuja target is the high level of external debt experienced in many countries that translates into interest payments and debt repayments consuming a considerable share of government budgets. Debt relief efforts under the HIPC initiative have, in many instances, been wholly inadequate. The recent G8 'debt cancellation' initiative may

hold more promise in enabling governments to devote more of their limited tax funding to the provision of health and other social services (many of which also contribute to health status improvements). However, this debt relief will be provided over a period of 40 years which will once again translate into relatively small annual reductions in the debt burden and there are also concerns about the conditionalities linked to this debt relief. A wider range of more substantive efforts to reduce the debt burden on African governments is required.

Donor funding

The trend towards the Sector Wide Approach (SWAp) in donor funding has been largely positive in the African context. It has contributed to improved coordination mechanisms for managing donor finances and promoted the use of donor funds in line with domestic policy priorities. There are concerns about some donors' recent move away from health sector pooled funding to general budget support (i.e. where all donor funds are given to Treasury and allocation between sectors is part of the normal budgeting process). Part of the concern is whether the health sector will receive a 'fair share' of donor funds under this arrangement. Another concern is that this could potentially undermine the role of the Ministry of Health in crucial areas of health policy, particularly in relation to health care financing. Given that Ministries of Finance wield considerable power in many African governments and are frequently more responsive to donor demands than sectoral Ministries, it is possible that donors could attempt to impose their health sector priorities (especially their views on health care financing strategies) via applying pressure on Treasury officials who in turn could apply pressure on Ministry of Health officials.

Out-of-pocket payments, especially user fees

The key development in relation to user fees in recent years is the removal of fees for some or all health services in some African countries, such as South Africa and Uganda, and the mounting pressure on other African countries to adopt a similar policy. The experience in countries that have removed fees was that there were rapid and large utilisation increases, especially for the poor. However, the experience of fee removal has not been entirely positive (e.g. declining staff morale due to increased workload and problems in the implementation process, and drug shortages as utilisation levels increased) and highlights the need for careful planning and adequate resource improvements before such a dramatic policy change is introduced. With the introduction of 'free care' in Uganda, there were simultaneous substantial increases in district health service funding which mitigated some of the problems that arose in South Africa. However, much of these additional resources came from external sources, and there are concerns about the sustainability of these levels of funding if external funds are withdrawn. In essence, the experience to date demonstrates the need for detailed and adequate planning, careful and active management of the responses of health workers and managers, and improved resource availability (particularly domestic resources) if fees are removed to continue to provide adequate quality services in the face of increased utilisation.

Health insurance

In recent years, there has been a growing emphasis among international organisations on health insurance as a financing mechanism. For example, the 2005 World Health Assembly passed a resolution encouraging member states to pursue social and other forms of health insurance.

As indicated previously, health insurance is still relatively limited within Africa. Private voluntary insurance schemes for formal sector workers are mainly concentrated in Southern Africa (particularly South Africa, Zimbabwe and Namibia) but also exist to a more limited extent in some East and West African countries. Experience of these

types of schemes has not been entirely positive, with very limited coverage levels, fragmentation of risk pools and rapid, uncontrolled cost spirals threatening their sustainability. For these reasons, justifiably limited attention is being paid to expanding this form of health insurance within the African context.

Instead, the option of community-based health insurance (CBHI) schemes (sometimes called community pre-payment schemes or mutual health organisations) is rapidly gaining favour. As these schemes are funded by annual or more frequent contributions, but do not require payments at the time of using health services, they lower financial barriers to access. There is also some degree of cross-subsidy, particularly from the healthy to the ill. From these perspectives, CBHI is a preferable alternative to out-of-pocket payments. However, there is still quite weak empirical evidence on what works and what doesn't. Experience to date shows that population coverage by these schemes has remained relatively low, and that the most vulnerable households are not currently incorporated. Thus, most of these schemes have small risk pools and limited cross-subsidies. Given that there is an urgent need for more work to explore how the viability, sustainability and equity contribution of such schemes can be strengthened before they can be introduced on a wide scale, it is of concern that some international stakeholders are advocating these schemes as the new 'one size fits all solution' to the health care financing gap in African countries.

Another option that is being considered or introduced in a growing number of African countries is that of mandatory health insurance (i.e. where legislation makes it compulsory for all or some citizens to become members of a health insurance). Tanzania recently introduced a social health insurance (SHI) covering civil servants, which is now being extended to formal sector workers in the private sector. South Africa is also putting in place the key elements that will underpin a future SHI, and will also begin with mandatory insurance for civil servants. The major potential benefit of introducing a SHI is that it would relieve the burden on publicly-funded health services; SHI members would either use private sector services or where they do use public services, the SHI would reimburse the full cost of these services. However, there are two important concerns with the SHI approach. Firstly, it entrenches a two tier health system, creating a deep divide between the insured, who have excellent access to a wide range of high quality health services, and the uninsured who often are consigned to under-resourced public sector services for the poor. Secondly, the first group to be covered by mandatory health insurance are civil servants and limited government funds will be used for this purpose and there may be fewer government resources available for providing services for those who are dependent on publicly-funded services.

Some African countries, such as Ghana, are seeking to combine SHI for formal sector workers with district-wide CBHI schemes in order to implement a universal national health insurance (NHI) system (Kenya is proposing a similar approach, but these plans are currently 'on hold'). The contributions of low income households will be partly or fully subsidised out of tax and pooled donor funds, and there will be risk-equalisation between the individual district schemes and the scheme for formal sector workers. For countries that have opted for NHI from an early stage, there are certain benefits but also considerable challenges. The major benefit from an equity perspective is that there is the political intention to achieve universal coverage in an integrated health system from the outset in the shortest possible period. However, a key challenge is that of sustainability. Considerable administrative, financial management and actuarial capacity is needed in order for the NHI to succeed. In addition, in the context of a small formal sector, with those outside the formal sector only able to make limited financial contributions, and high poverty levels, there are

serious concerns about the financial viability and sustainability of the NHI scheme. Clearly substantial government (and donor) funding is needed, but there is uncertainty about whether these resources will be adequate to cope with the increased utilisation of health services that will inevitably arise when financial barriers to accessing services are removed.

Implications for policy, advocacy and research

On the basis of this review, the following actions are recommended in relation to health care financing within the African context:

- Explicit commitments by African governments to move away from out-of-pocket funding of public sector health services, and actively pursuing alternative financing mechanisms to make this a reality.
- Efforts to increase tax revenue through improved tax collection mechanisms and more appropriate corporate and wealth taxation strategies.
- Urgent efforts to increase the health sector's share of government resources in line with the existing commitment of African Heads of States, made in Abuja in 2001, to a 15% share for health.
- Unconditional cancellation of African governments' external debt, to allow governments to devote limited tax revenue to health care to achieve the Abuja goal, rather than to debt servicing and repayment.
- As general tax funding and health insurance options are most closely aligned with the above principles, introducing or expanding insurance mechanisms to supplement limited tax resources should receive considerable attention, including detailed research of context-specific insurance options, monitoring and evaluation of insurance initiatives currently being implemented in some countries, sharing of experiences across the region and increased policy dialogue about these options.
- Active management of donor funding, to ensure that national Ministries of Health lead and control decisions on the use of these funds to ensure that they contribute to achieving national health priorities.
- Implementing *effective* mechanisms for identifying the poor and other vulnerable groups. Even if there is a move away from user fees for public sector services in favour of health insurance mechanisms to supplement tax funding, it will be necessary to protect poor and other vulnerable households by either fully or partially subsidising membership of these schemes or ensuring appropriate access to tax funded health services.
- Equitable allocation of funds that are mobilised through the above strategies, to ensure that all citizens of African countries have access to health services irrespective of whether they reside in a rural or urban area.
- Careful planning for the implementation of any of new financing policy developments. The range of strategies that can support implementation include ensuring that the views of beneficiaries are taken into consideration when designing new policies, gaining support from the health staff responsible for implementation, and ensuring monitoring and evaluation systems that do not simply measure progress towards targets, but rather represent 'early learning' mechanisms that allow the process, as much as the design, of interventions to be adapted as implementation proceeds.

These actions need to be supported by detailed research, dissemination of evidence, exchange of information on promising practice and policy dialogue to provide and use a good evidence base to promote the design and implementation of equitable health care financing systems. EQUINET plans to initiate a program of research, information dissemination, policy dialogue and support of policy processes to contribute to the development and uptake of this evidence base.

1. INTRODUCTION

This paper has been commissioned by the Regional Network for Equity in Health in east and southern Africa (EQUINET) to inform the development of a new program of work on equitable financing. In recent years, EQUINET has focused much of its health care financing work on the issue of resource allocation. The new program of work will focus primarily on resource mobilisation issues. Hence, this paper provides a critical assessment of the state of knowledge on the mobilisation of health care resources in the African context as a starting point for the new program. It focuses primarily on domestic health care financing options. Although it briefly refers to issues related to external debt issues and donor funding, it does not consider wider macroeconomic policy issues associated with interaction with international institutions nor on options to reverse the flow of resources out of Africa. While we recognise that this would increase the level of domestic resources available for health care, these issues are addressed in another EQUINET paper (Bond, 2005).

There are a number of reasons why it is important to focus on the issue of resource mobilisation in Africa at this point in time. Firstly, the lack of financial resources in African countries to adequately meet the health service needs of their populations remains a persistent problem, and is becoming even more critical in the context of the rapid growth of the HIV/AIDS epidemic and factors such as the need to introduce more expensive combination therapy for malaria due to widespread resistance to chloroquine and other relatively inexpensive monotherapies. Secondly, there is growing evidence of the adverse impact of some of the health care financing reforms introduced in Africa during the late 1980s and 1990s, particularly in relation to the untenable burden placed on individual households, which in some cases contributes to household impoverishment. There is thus an urgent need to identify ways of reversing the damaging financing reforms of previous decades. Thirdly, new health care financing approaches are being proposed, and in some countries already being introduced, making this an opportune time to critically assess these approaches. Of particular importance in this regard are: the renewed interest in removing user fees from some or all health services, which has already been taken forward in a few countries such as South Africa, Uganda and to some extent in Kenya and which is the subject of growing advocacy initiatives; increasing emphasis on health insurance mechanisms, with efforts to expand insurance coverage being introduced in a number of African countries and a resolution at the 2005 World Health Assembly encouraging even greater pursuit of insurance strategies; and the move by some donors to provide general budget support (i.e. channelling all donor funds via the Ministry of Finance) rather than direct funding to the health sector. While some of these approaches may be beneficial, others may not and it is important for individual countries and regional groupings to be fully informed of the likely impacts of each initiative so as to avoid the historical tendency for reforms to be imposed on African countries by international organisations rather than being locally developed and driven. Fourth, the context within which health care financing decisions are made has changed. A key issue is the debt relief initiatives of the last few years, and very recently the cancellation of debt for some countries, which provides a real opportunity to consider alternatives such as increased tax funding of health services which has not been a realistic option over the past decade or so. A related issue is current international debates (e.g. in the High Level Forum) about the level of 'fiscal space' that countries have, i.e. the scope for increased government expenditure on key social services and advocacy for changes in macroeconomic policies and global trade relations that may create more fiscal space. Finally, there is a need to recognise that policy developments in health care delivery, such as continued commercialisation of health services, have profound implications for health care financing strategies.

For the above reasons, it is necessary to critically evaluate how health services are currently funded, explore recent trends in health care financing and identify lessons from the health care financing experience of African countries. Although EQUINET focuses mainly on Southern and East Africa in its activities, there are important lessons to be learnt from West African countries and thus, this paper reviews relevant experience throughout Sub-Saharan Africa (SSA). In addition, it is important to consider the way forward and particularly key issues in considering future options for *packages* of financing mechanisms, rather than focusing simply on the pros and cons of *individual* financing options as has been done in the past. Not only is it important to recognise that no country uses a single mechanism to finance their health services, but it is essential to begin to take a more comprehensive view of health care financing in order to see the inter-relationships between different financing mechanisms and the way in which they either contribute to or work against overall health system equity. While future options will be reviewed, the emphasis will be on developing a set of equity-focused principles that can be used to guide detailed evaluation of options for financing packages within individual country contexts, given that 'one size does not fit all'.

The paper is structured as follows:

- The next section defines key concepts in terms of health care financing equity, and provides a brief overview of international empirical evidence on the relative equity of the main health care financing mechanisms;
- Section 3 reviews how health services are currently financed in SSA countries;
- Section 4 provides a detailed review of recent experience of alternative health care financing mechanisms in SSA countries, with individual sub-sections on each of the major financing mechanisms and a final section highlighting key issues in relation to overall health care financing patterns;
- The final section considers the implications of this review in terms of policy directions and areas for future advocacy and research.

2. Equitable health care financing: key concepts

Before examining current patterns and recent trends in health care financing in African countries, it is important to provide broad definitions of the concept of equitable financing and to briefly explore international empirical evidence on the equity of different financing mechanisms. This provides a background against which to assess experience with individual financing mechanisms in Africa. The final section of this paper considers in more detail what principles should underpin future health care financing developments in the African context.

There is consensus that equity in health care financing should be related to an individual's ability to pay. More specifically, it is accepted that individuals (or families) with different ability to pay should make 'appropriately dissimilar payments' for health care with higher income individuals paying more than those with a lower income level (referred to as vertical equity). At the same time, it would also be equitable for individuals (or families) with the same ability to pay to contribute the same amount towards their health care costs (referred to as horizontal equity) (Wagstaff and Doorslaer, 1993). However, there is less agreement on what is meant by 'appropriately dissimilar payments'. Those with greater ability to pay may pay a higher percentage of their income than lower income groups (i.e. payments may be progressive), or they may simply pay more in absolute terms (i.e. payments may be proportional, where everyone contributes the same percentage of their income, or even regressive, where the poor pay a higher percentage of their income than the rich). EQUINET has previously indicated that it supports the concept of vertical

equity, but as illustrated above, this simply means that the rich should pay more than the poor in relation to the burden of health care financing. We would argue that, within the African context of high poverty levels and the inability of many households to afford even relatively small payments towards health care, combined with substantial inequities in the distribution of income across households, vertical equity in health care financing should be interpreted as a strong preference for progressive financing mechanisms.

When considering the equity of health care financing, one can not simply consider who bears the burden of paying for health services; it is equally important to consider who derives the benefit from each source of finance. In this paper, equity in service benefit is defined as individuals benefiting on the basis of their need for health services and not on their ability to pay. Thus, it is the combination of the distribution of health care payment burdens relative to ability to pay, and the distribution of health service benefits relative to need, that determine the equity of individual health care financing mechanisms.

A growing number of studies are being undertaken to evaluate the relative progressivity of different types of health care financing and the distribution of benefits according to need for health services. Initially these focused mainly on high income countries (Van Doorslaer and Wagstaff, 1993, Wagstaff et al., 1999), but some evidence now exists for low- and middle-incomes, particularly in Asia (EQUITAP, 2005). These studies demonstrate that:

- General tax revenue is usually the most progressive health care financing mechanism. However, this depends on the type of taxes levied and the relative contribution of each tax to overall government revenue. For example, personal income tax is generally progressive whereas 'indirect' taxes on goods and services (such as Value Added Tax – VAT, or General Sales Tax – GST) are frequently regressive. If a high proportion of general tax revenue comes from VAT or GST, the overall tax system may be regressive. It should be noted that recent evidence from Asia indicates that indirect taxes may not be regressive in some countries (EQUITAP, 2005), particularly where the informal sector is large and the major purchases of poor households are for fresh food produce that escapes the VAT or GST net. On the benefit side, there is mixed evidence. Funding of health services from general tax revenue can preferentially benefit those with the greatest need for health care, if it is appropriately allocated. However, a number of studies on the distribution of benefits from publicly (tax) funded services in African countries have shown that the rich benefit most from these services (Castro-Leal, 1996, Castro-Leal et al., 1999, Demery et al., 1995). This usually occurs when a major share of tax funding is allocated to large, expensive, urban-based hospitals rather than to primary care services and services in rural areas.
- Mandatory health insurance (i.e. where certain individuals and groups are required by law to contribute to a health insurance scheme) in many high-income countries is regressive. This is dependent on how contribution rates are structured, particularly whether there is a flat rate contribution, which is highly regressive, or a contribution rate that increases with income. In addition, the existence of a maximum ceiling rate, where no individual should pay more than this amount irrespective of their income, tends to make the insurance regressive. Recent evidence from Asia shows that mandatory insurance is usually progressive in these low- and middle-income countries. However, this is largely attributable to the fact mandatory insurance in these countries only covers those in formal sector employment, who are the highest income individuals. As noted in the Asian study, "One must be careful not to place a redistribution interpretation on these results. In partial social insurance systems, the better-off do not only pay more, they get more. The poor do not contribute but they are also denied the benefits of

coverage" (EQUITAP, 2005). This highlights that where mandatory health insurance covers only a section of the population, the distribution of the benefits from health services funded from this source may be distributed according to need *within* the insured population, but given that the uninsured frequently have even greater need for health services than the insured, the distribution of benefits in the overall health system is not enhanced through this financing mechanism.

- Private voluntary insurance follows a similar pattern to that for mandatory insurance. In high-income countries which have a large private voluntary insurance component, it tends to be a regressive financing source. In most of these countries, private insurance contributions are related to the risk of illness of the member (e.g. older and chronically ill members pay higher premiums than young, relatively healthy individuals) and this makes them more regressive than mandatory insurance systems (Van Doorslaer and Wagstaff, 1993). In lower income countries, this financing mechanism is again likely to be progressive to some extent because only the higher income groups belong and contribute to such schemes. Importantly, however, the benefits of these financial resources only accrue to these richer, contributing groups, as a result of ability to pay rather than need being the basis of benefit distribution. Private insurance is, thus, inimical to equity in any context, except where it only offers a 'top-up' to a comprehensive basic package of services available to all on the basis of need.
- Out-of-pocket payments are generally a regressive form of financing and tend to be the most regressive way of funding health services (Van Doorslaer and Wagstaff, 1993). This is partly related to the fact that those with the lowest income levels tend to bear the greatest burden of ill-health and thus bear the greatest financing burden as payment is directly linked to use of health services. Out-of-pocket payments, in systems where a relatively large share of health care financing is attributable to this source, will always be regressive unless the majority of low-income people simply do not use health services when needed. From the perspective of health service benefits, out-of-pocket payments are also inimical to equity, as benefits are distributed solely on the basis of ability to pay rather than on the basis of need for health care.

No country relies entirely on a single health care financing mechanism, but rather uses a combination of these mechanisms as an overall health care financing package. The extent to which the overall health care financing package is equitable or not depends on the relative share and equity or inequity of each financing mechanism, both in terms of the distribution of the burden of health care payments (financing incidence) and the distribution of health service benefits (benefit incidence). Appendix A provides a detailed and (hopefully) user-friendly overview of how the financing and benefit incidence of individual financing mechanisms influence overall health system equity.

This brief introduction to health care financing equity issues provides a backdrop against which to review current health care financing patterns in Africa and recent financing policy developments.

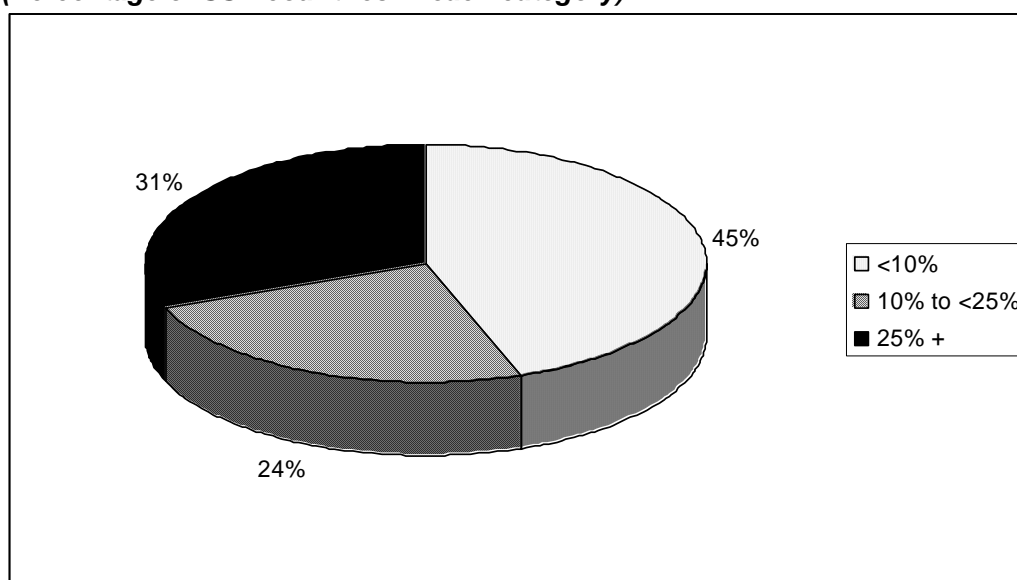
3. Overview of current health care financing in African countries

A useful starting point for considering future health care financing options for African countries is to review current financing patterns. Thus, this section provides a brief overview of the major sources of health care financing in Sub-Saharan Africa. It is based on data for 2002 drawn from the World Health Organisation's National Health Accounts (NHA) database (<http://www.who.int/nha/country/whrannex/en>). While there are questions about the accuracy of NHA data in some African countries, this is the only reasonably comprehensive global database on health care financing and expenditure available and is adequate for illustrating key features of health care

financing and expenditure in Sub-Saharan African countries. A key problem with the NHA dataset is that data on 'government' spending on health care includes that which is funded from national tax revenue and from donor sources, i.e. it is impossible to determine exactly how much funding government is contributing to health care from its domestic tax sources alone. Despite these drawbacks in the available data, a number of key issues relating to health care financing in sub-Saharan Africa (SSA) can be identified (see Appendix B for full data on health care spending in SSA countries).

There is still a relatively heavy reliance on donor funding in some countries. The figure below shows that external funding as a percentage of total health care expenditure is 10% or more in 55% of SSA countries. Donor funds account for more than a quarter of health care expenditure in 31% of countries, and account for as much as 66% of expenditure in some countries (Benin). It should be noted that these external funds do not only flow via government but may also go directly to the private sector (e.g. to mission hospitals).

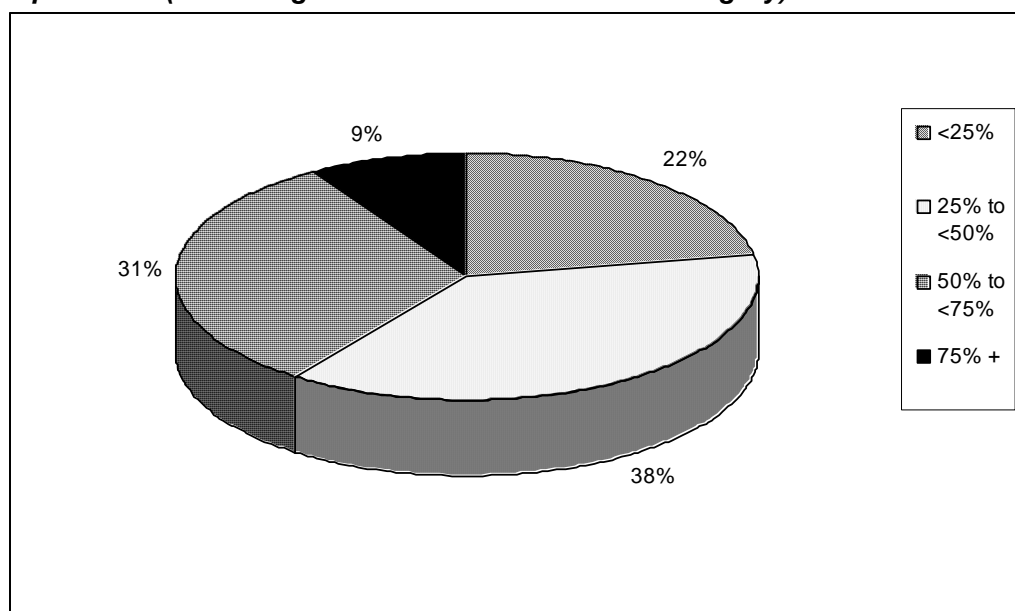
Figure 1: External funding as percentage of total health care expenditure (Percentage of SSA countries in each category)



Source: World Health Organisation NHA database (2002 estimates)

There are very high levels of out-of-pocket payments in most African countries. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, ranging from doctors working in private practice to informal drug sellers and traditional healers. Figure 2 indicates that these payments account for 25% or more of total health care expenditure in 78% of African countries. In 40% of SSA countries, more than half of all health care expenditure is funded through out-of-pocket payments.

Figure 2: Out-of-pocket payments as percentage of total health care expenditure (Percentage of SSA countries in each category)



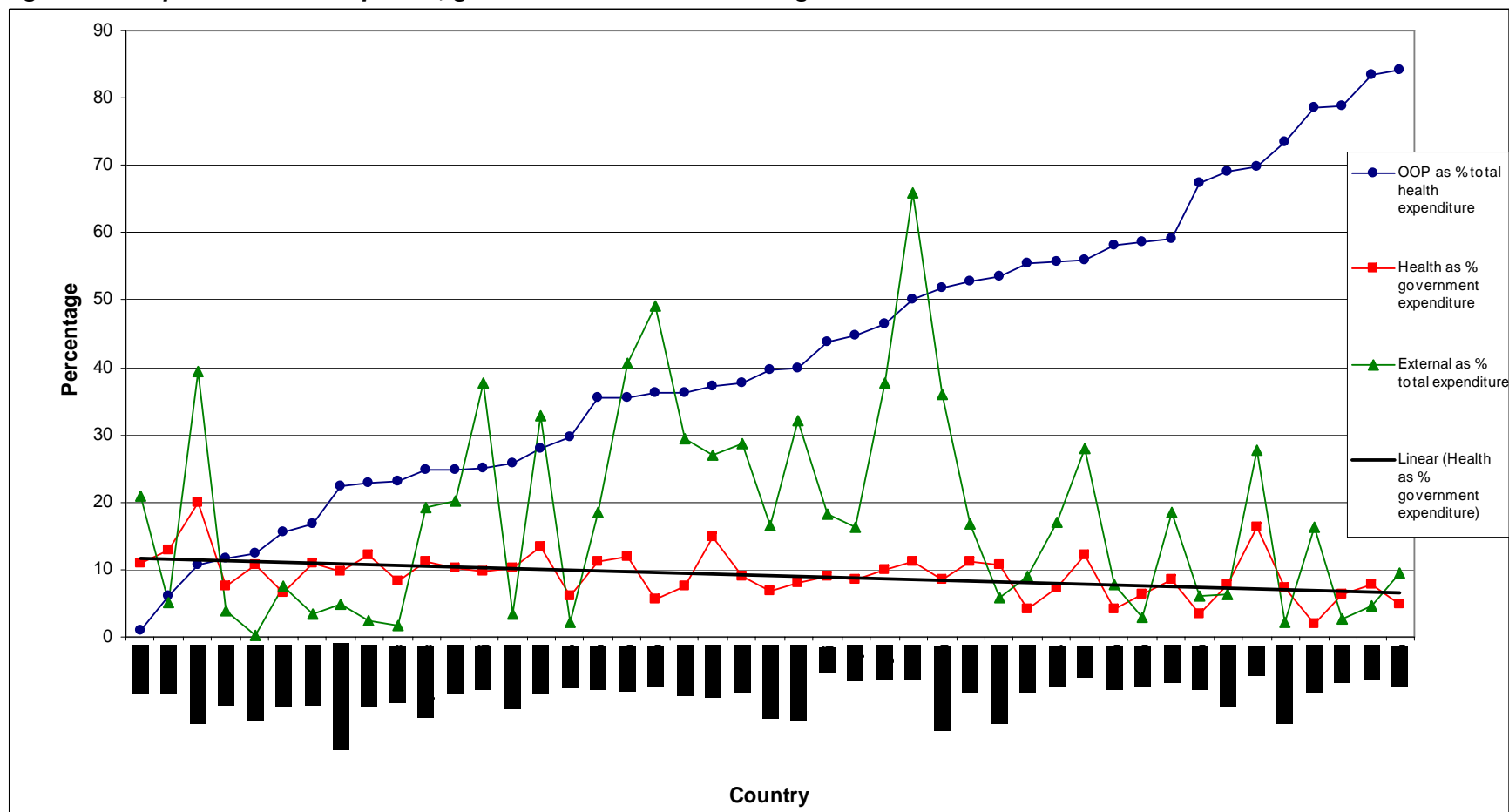
Source: World Health Organisation NHA database (2002 estimates)

Levels of tax funding for health services are relatively low. Only three African countries have close to or above 15% of total government expenditure being devoted to health care, namely Tanzania at 14.9%, the Democratic Republic of Congo (DRC) at 16.4% and Mozambique at 19.9% in 2002. However, the WHO NHA database includes donor funds channelled via the government in these estimates¹. As 27% of total health care expenditure in Tanzania, 28% in the DRC 39% in Mozambique is funded from donor or external sources, it is clear that government resources excluding donor funds do not exceed 15% in any of these countries. The majority (60%) of Sub-Saharan African countries have levels of government health care expenditure of less than 10% of total government expenditure (including both local tax funding and external donor funding). Most of the countries with health care expenditure levels above 10% of total government expenditure have relatively high levels of donor funding, with the exception of Burkina Faso, Namibia, South Africa, Swaziland and Zimbabwe.

One interesting trend that is observable from the NHA data (see Figure 3) is that in countries where there is a commitment to devoting a relatively large share of government resources to the health sector, the burden of out-of-pocket payments is kept relatively low. Figure 3 orders countries in terms of the percentage share of total health care expenditure attributable to out-of-pocket payments, from lowest to highest. This can be compared with the percentage share of government expenditure devoted to health which, as the trend line shows, declines on average as out-of-pocket expenditure levels increase. While there is no clear pattern in terms of external funding, it is positively correlated with the health sector's share of total government expenditure.

¹ This is a very serious deficiency of the WHO NHA dataset. The combination of donor funding with tax funding in this dataset makes it impossible to monitor progress towards the Abuja target.

Figure 3: Comparison of out-of-pocket, government and donor funding levels in Sub-Saharan African countries



Source: World Health Organisation NHA database (2002 estimates)

Another factor that influences the share of out-of-pocket payments in overall health care expenditure is the extent of health insurance (or pre-payment) schemes' coverage in a particular country. In general, health insurance is very limited in SSA. Private insurance of any magnitude is largely restricted to Southern Africa (including Botswana, Madagascar, South Africa, Swaziland, Zimbabwe; and Kenya in East Africa). In these countries, the major type of insurance is private voluntary coverage of formal sector employees. There has been a recent growth in community health insurance (pre-payment) schemes in some countries, particularly in Central and West Africa and more recently in East and to a limited extent Southern Africa, but this remains a very small component of overall health care financing at present. Any sizeable pre-payment via social security funding is largely restricted to West Africa (Cape Verde, Cote d'Ivoire, Mali, Senegal and Togo), and is non-existent in the vast majority of countries.

In summary, the key health care financing patterns in SSA are:

- The current level of health care funding from government tax revenue is relatively low;
- There is still a reasonably high level of reliance on donor funding;
- There is limited insurance coverage, especially in relation to mandatory health insurance;
- One of the single largest sources of financing is that of out-of-pocket payments.

4. Recent developments in health care financing in Africa

4.1 Tax funding

There has been almost no discussion of increasing tax funding for health services in African countries over the past few decades (until very recently); it was simply not seen as an option worth considering. Many African countries were experiencing extremely limited economic growth, if at all, and when combined with the requirements to reduce government expenditure as part of Structural Adjustment Program (SAP) conditionalities, governments were extremely constrained in the allocation of tax funding towards health services.

This situation has changed in recent years and increased tax funding for the health sector is now receiving attention. There are a number of factors that have contributed to this, including:

- An emerging consensus that the health care financing reforms of the 1980s and 1990s, such as user fees and other 'cost recovery' or 'cost sharing' initiatives, did not live up to the promise of generating substantial additional resources for health care and in some respects created a host of other problems. In the face of a growing burden of illness associated with the HIV/AIDS epidemic, and the need to introduce more costly treatment strategies for priority diseases, such as artemisinin-based combination therapies for malaria due to drug resistance problems, there is an interest in seriously considering the potential for increased funding from tax revenue sources.
- Recent empirical evidence shows that health systems in low- and middle-income countries that have a large and strong public sector, which is substantively funded through tax revenue, are most equitable (both in relation to progressive financing and access according to need). This has been particularly highlighted in a large cross-country study in Asia which has shown that Hong Kong, which has a largely tax funded system, has one of the most progressive health care financing systems (EQUITAP, 2005). In addition, Hong Kong stands out as having the most strongly pro-poor distribution of health service benefits, followed by Malaysia, Thailand and

Sri Lanka, all of which have 50% or more of total health care expenditure funded from government revenue sources (EQUITAP, 2005)

- The recognition of the importance of general tax funding as the cornerstone of effective health systems in the African Heads of State's commitment to increase tax funding for health services. This was made as part of the "Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases", where it was recognised that "there is a need to secure adequate financial and human resources at national and international levels" in order to successfully address the HIV/AIDS pandemic. The Heads of State pledged themselves to "a target of allocating at least 15% of our annual budget to the improvement of the health sector" (OAU, 2001).
- Recent debt relief initiatives have raised the possibility that African governments may be able to devote less of their limited tax funding to paying interest and repaying external debt and direct more tax resources to health and other social services.

Before considering in greater detail the extent to which these and related factors have (or haven't) already contributed, or could potentially in future contribute, to increased tax funding of health services, it is useful to consider the key variables that determine the amount of government funding devoted to the health sector. Hay provides a helpful 'formula' in this regard:

$$\begin{aligned} \text{Government expenditure on health services per capita} = & \\ & \text{Gross Domestic Product (GDP) per capita} \times \\ & \text{Share of GDP devoted to government expenditure} \times \\ & \text{Share of government expenditure spent on health services (Hay, 2003)} \end{aligned}$$

This 'formula' highlights the importance of the size of the economy and economic growth rates, policy decisions about the size of the government sector relative to the rest of the economy (which is influenced by the amount of tax revenue generated and the ability to secure loans and/or grants) and finally the prioritisation of the health sector relative to other sectors in government policy.

Size of the economy and economic growth rates

An indication of the size of the economy, or level of overall income, is provided for each SSA country in Appendix B, expressed in terms of GDP² per capita. There are wide differences in this indicator between countries, ranging from US\$99 per capita in Ethiopia, US\$ 103 in the DRC and US\$117 in Burundi to US\$7,017 per capita in the Seychelles, US\$4,097 in Gabon and US\$3,690 Botswana.

Overall, the average Gross National Income (GNI)³ per capita in Sub-Saharan Africa is US\$460, which is slightly higher than the average for all low income countries (US\$390). Average per capita GNI is nearly 3 times greater in lower-middle income countries (US\$1,250) than in SSA, more than 8 times greater in upper-middle income countries (US\$3,730) and 57 times greater in high income countries (US\$26,150) (data from World Bank Development Indicators website).

To state the obvious, African countries have extremely limited economic resources, constraining their ability to generate tax revenue and to fund health and other social services. This is exacerbated by the relatively slow rate at which African economies have been growing, although this situation has improved in recent years. Table 1

² GDP is the total market value of all goods and services produced in a country in a given year.

³ GNI not only includes the value of goods and services produced within a country (i.e. GDP) but also includes income from economic activities between this country and the rest of the world (e.g. interest earned by local residents on investments abroad)

shows that the annual GDP growth rate in real terms (i.e. removing the effects of inflation) has been higher in SSA countries than in 'advanced economies' in most years during the period 1995-2002. It has also generally far exceeded that in 'countries in transition', but has consistently been well below the average for all developing countries, largely because of the considerably faster growth rates in developing countries in Asia.

Table 1: Annual growth in real GDP

Category/Region	1995	1996	1997	1998	1999	2000	2001	2002
Advanced economies	2.7	2.9	3.5	2.7	3.4	4.1	1.9	2.7
Countries in transition	-1.5	-0.5	1.6	-0.9	2.6	5.8	4.0	4.2
Developing Asia	9.0	8.2	6.6	4.0	6.1	6.9	5.9	6.4
Africa	3.0	5.7	2.9	3.3	2.3	3.0	4.2	4.4
Developing countries	6.1	6.5	5.8	3.5	3.9	5.8	5.0	5.6

Source: World Economic Outlook indicators, World Bank website

Share of GDP devoted to government expenditure

In the late 1990s, total government expenditure accounted for about 24% of GDP in African countries on average, compared with an average of nearly 29% in middle-income countries and an average of over 32% in high-income countries (Commission on Macroeconomics and Health, 2002). There are even wider differences if individual countries are considered, ranging from 11% in the Democratic Republic of Congo (DRC) and 12% in Cameroon to 47% in Kuwait and 48% in the Netherlands. This is partly attributable to macroeconomic policies adopted in many African countries which explicitly attempted to reduce the level of government expenditure. Frequently these policies were imposed on African governments by means of Structural Adjustment Programs associated with IMF and World Bank loans. There is growing international debate about the need to reverse these macroeconomic policies in order to create the 'fiscal space' to improve government spending on social services.

As indicated previously, another important factor influencing government spending as a proportion of total economic activity is the extent of tax revenue that is generated. While African countries tend to have a small tax base (i.e. a small amount of economic activity and small number of people in formal employment from which tax revenue can be secured), and there are concerns not to place too heavy a burden on the limited number of registered tax payers (and substantial opposition by these groups to any tax rate increases), there are ways in which tax revenue can be increased. For example, tax revenue has grown considerably in recent years in South Africa, despite the fact that personal income tax rates have been reduced systematically over this period (National Treasury, 2005). The main reason is that tax collection has been improved through more careful assessment of income tax returns and imposing heavy penalties on those who defraud the tax authorities. Another way in which tax revenue could be increased is through appropriate corporate and wealth taxation mechanisms. As highlighted in another recent EQUINET publication, many foreign corporations are relocating massive profits earned in African countries with minimal tax revenue being collected by the African government (Bond, 2005). Thus, there is an urgent need for improved tax collection systems in African countries in order to facilitate increasing government expenditure as a share of GDP.

Share of total government expenditure on health

The final issue that influences government health spending levels is the share of total government expenditure devoted to the health sector, i.e. the extent to which health receives political priority relative to other sectors in the government expenditure decision-making process. In most African countries, the education sector receives more than double the amount that the health sector receives (Commission on Macroeconomics and Health, 2002). However, it should be recognised that improved educational status of the population has been shown to positively contribute to improved health status. Nevertheless, it is critical for public health services to be adequately funded in order to secure substantial health status improvements. It is of far greater concern that defence receives more resources than the health sector in most African countries. It is unsurprising that countries experiencing civil conflict would have high levels of defence spending, e.g. over 25% of government spending in Burundi was devoted to defence in 1997-1998 compared with a mere 2.5% devoted to health and 15% on defence and less than 1% in the DRC. However, it is concerning that nearly 11% of government expenditure is devoted to defence and only 4% to health in countries without conflict such as Cameroon (Commission on Macroeconomics and Health, 2002). Advocacy around the Abuja commitment to devote 15% of government resources to health care is critical in changing this relative prioritisation between sectors.

The other factor that constrains government's ability to devote a higher percentage of total government spending to health is debt servicing and repayment. Interest payments on debt accounted for 12% of total government expenditure in Zambia in 1997-1998, 14% in Ghana, 22% in Cameroon and 26% in Kenya (Commission on Macroeconomics and Health, 2002). This highlights the importance of considering ways of relieving the debt burden on African countries.

HIPC & G8 debt relief

As indicated earlier, there is some optimism that recent debt relief initiatives may allow African countries to increase the amount of tax funding devoted to health care expenditure. The first major debt relief initiative was the Heavily Indebted Poor Countries (HIPC) initiative. It is worthwhile considering whether this initiative had a positive impact on health care expenditure in African countries that have benefited from it.

HIPC is a joint initiative by the World Bank and the International Monetary Fund (IMF) developed in 1996 to provide a framework for multilateral and bilateral creditors to reduce the levels of sovereign debt owed to them by the poor countries identified as highly indebted. In order to understand the implications that the HIPC initiative may have for health financing it is important to understand its objectives and general functioning. The Original HIPC initiative (O-HIPC) was broadly defined and aimed to reduce the recipient country's debt burden which clearly constrained economic growth and development. The initiative has since evolved to what is called the Expanded HIPC (E-HIPC) which has been modified to include three clearly specified objectives which are to (Gautam, 2003):

- Provide a permanent exit from debt rescheduling
- Promote growth
- Release resources for higher social spending targeted at poverty eradication.

Qualification for HIPC debt relief occurs in two main stages; the first stage is called the Decision Point and the second stage is called the Completion Point. At the Decision Point, countries receive conditional interim debt relief if they have an interim Poverty Reduction Strategy Paper (PRSP), a track record of macroeconomic stability

and have cleared all debt arrears (i.e. if the country had fallen behind in its debt repayments, they must pay off these outstanding amounts before they can receive interim debt relief). To receive the full amount of irrevocable debt relief at the Completion Point countries must maintain macroeconomic stability under the IMF's Poverty Reduction Growth Facility (PGRF), implement the structural and social reforms (particularly in terms of focusing public spending on 'poverty-reducing' social services) agreed upon at the Decision Point and implement a PRSP successfully for one year.

Exactly how the elimination of debt servicing will translate into economic growth and poverty reduction is not clear except that in order for countries to qualify they must have a PRSP in place which sets out plans, targets and measurable outcomes for social spending in support of poverty reduction. To date there are 38 countries identified for HIPC relief, 32 of which are in Sub-Saharan Africa.

The aim of debt relief under HIPC is to release fiscal resources for social sector spending towards promoting growth and eradicating poverty. An interesting question is whether there is any evidence of countries at decision or completion point expanding their social spending, especially their health spending, and if there is competition between social sectors for additional resources or if there are specific social sectors which are noticeably receiving more funding. The evidence shows that general social spending in support of poverty reduction is indeed taking place and has been prioritised to increase in medium term expenditure planning (see Appendix C for an overview of trends in the 4 African countries that have reached the HIPC completion point – Ethiopia, Ghana, Mozambique and Uganda). However in most cases, the education sector is the major beneficiary while the health sector is receiving much smaller increases in general tax funding as a result of HIPC debt relief. The dilemma between increased funding of education, which would positively (albeit indirectly) contribute to health status, and increased funding for health services, which are critical to achieving health status improvements was raised earlier.

One of the criticisms of the HIPC initiative is that it translated into relatively small amounts of debt relief relative to the size of the total debt burden (McIntyre et al., 2005). For example, at the end of 2002/03, Ethiopia (which is listed in the World Bank classification according to Gross National Income per capita in 2003 as having the lowest income level at US\$ 90 of all countries) had a nominal stock of external debt amounting to US\$6,845 million, which is slightly more than 100 percent of Gross Domestic Product (GDP). Debt relief to Ethiopia under the HIPC initiative in 2001/02 amounted to \$50 million (0.8 percent of GDP) and in 2002/03 totalled \$62 million (0.9 percent of GDP) (IMF and IDA, 2004).

The most recent debt relief initiative, announced at the 2005 Gleneagles G8 Summit, "to cancel 100% of outstanding debts of eligible Heavily Indebted Poor Countries to the IMF, IDA [lending part of the World Bank] and African Development Fund" (G8, 2005) appears to hold more promise than the initial HIPC initiative. While the HIPC initiative focused only on relief for the interest payments on the debt, the latest proposal will also provide relief on the principal loan (i.e. the money borrowed). In addition, it is required that the tax funds released through this debt relief be spent on social services. However, the debt will not be 'written off' with the stroke of a pen. Instead, the debt relief will be provided over a period of 40 years which will once again translate into relatively small annual reductions in the debt burden (Abugre, 2005). There are also concerns about the conditionalities that have been tied to the G8 initiative.

Thus, while the G8 debt initiative is a small step in the right direction, African countries still face an overwhelming debt burden and hence substantial constraints on their ability to direct a greater share of their tax revenue towards health services.

4.2 Donor funding

As indicated previously, most African countries rely heavily on donor funding to support human, social and infrastructural development. Table 2 illustrates the varying degrees of foreign aid support experienced by 4 of the African countries that have reached the HIPC completion point, and reveals that most countries receive substantially more aid per capita than the total amount they manage to spend per capita on health (from all public and private health care financing sources).

Table 2: Comparison of aid per capita and total health care expenditure per capita

HIPC Country	Aid per capita (current US\$)	Health Expenditure Per Capita (Current US\$)
Ethiopia	19.44	5
Ghana	32.01	17
Mozambique	111.39	11
Uganda	25.94	18

Source: World Bank Development Indicators (2005)

An analysis of donor support in a sample of Southern and East African countries (Table 3), shows that Mozambique and Zambia have consistently received the largest amount of aid per capita. The table also shows the variability in donor support on a year to year basis.

Table 3: Aid per capita, Selected Southern & East African countries

Country	Aid per capita (current US\$)				
	1999	2000	2001	2002	2003
Kenya	10.53	17.02	15.08	12.55	15.15
Malawi	44.24	43.28	38.38	35.1	45.42
Mozambique	46.52	49.57	51.61	111.39	54.96
Tanzania	30.07	30.33	36.9	35.04	46.51
Zambia	64.37	80.43	34.66	62.54	53.84
Zimbabwe	19.71	14.08	12.75	15.43	14.22

Source: World Bank Development Indicators (2005)

The face of donor support has gradually changed, initially from project funding to support under a SWAp (Sector-Wide Approach) framework in liaison with sectoral ministries, and most recently to General Budget Support (GBS) in liaison with Ministries of Finance.

The SWAp mechanism has been used to varying degrees in a growing number of African countries which rely heavily on donor funding. For example, a recent review indicated that Tanzania has the most well established SWAp making use of joint financing of sub-sectoral allocations (i.e. allocations to different components within the health sector), whilst Mozambique had only recently instituted pooled funding of government and donor funds within the health sector (Foster et al., 2000).

SWApS can be a useful tool for ensuring that donor and government funds are redistributed to ensure health system equity. For example, a SWAp based on open participatory planning and implementation in principle ensures that the health needs identified by civil society and NGOs are factored into health sector planning which could also promote equity. Experience with SWApS has however shown limited participation of civil society thus compromising potential equity effects (Foster et al., 2000). This is an issue that is being addressed in some countries, such as Tanzania, where a range of civil society stakeholders are involved in the annual health sector review process (Personal communication – Dr Max Mapunda). One of the most important means by which SWApS could improve health system equity is by ensuring that resource allocation is planned and executed comprehensively within the sector in line with national needs and priorities, as opposed to on a per project basis which encourages disparities where some areas are well resourced and others receive no resources at all (Walford, 2002). This requires that government policies, planning, budgeting and resource allocation need to be equity focused (Pearson, 2002).

General Budget Support (GBS) is a recently introduced mechanism used by some donor agencies to channel their funds through the central Ministry of Finance. These finance ministries are responsible for allocating, disbursing and managing these funds using the financial management, procurement and accountability systems already in place in government (DFID, 2004). Thus, under GBS, donor funds are no longer given directly to the Ministry of Health, but the ultimate decision on how much donor (and government) funds are allocated to the health sector rests with the Ministry of Finance, in consultation with key stakeholders, including donors providing GBS. DFID, which is one of the donors that has chosen to adopt a GBS approach, terms this kind of approach Poverty Reduction Budget Support (PRBS) and has identified it as “the aid instrument most likely to support a relationship between donor and developing country partners which will help to build the accountability and capability of the state” (DFID, 2004). According to DFID, the motivations of donors for this shift to GBS include:

- Increased ownership, empowerment and alignment of external funds with the national budget process and national priorities;
- Improved policy dialogue between governments and donors on key expenditure priorities, measures and implementation processes;
- Increased harmonisation of donor activities, benchmarks, reporting requirements and conditionalities;
- Increased predictability of donor funding over the medium term thus allowing for comprehensive planning of service delivery activities;
- Decreased transaction costs over the medium term as donor agencies would over time be using government's own accounting and reporting systems for monitoring;
- Improved efficiency in public expenditure management, expanded and more effective service delivery and more robust delivery institutions; and
- Potential for increased democratic accountability as the budgeting and planning system becomes more transparent allowing for more accountability.

There are some concerns about whether the health sector will receive a ‘fair share’ of donor funds under this arrangement. As noted earlier, the education sector receives greater priority than the health sector in the allocation of existing and any additional funds released from debt relief initiatives. While this may be appropriate, more attention does need to be paid to the relative prioritisation between the social sectors. Another concern is that this could potentially undermine the role of the Ministry of Health in crucial areas of health policy, particularly in relation to health care financing. Given that Ministries of Finance wield considerable power in many African governments and are frequently more responsive to donor demands than sectoral

Ministries, it is possible that donors could attempt to impose their health sector priorities (especially their views on health care financing strategies) via applying pressure on Treasury officials who in turn could apply pressure on Ministry of Health officials. A key issue is how the Ministry of Health manages its relationship with the Ministry of Finance as the 'guardian' of the budget, and its relationship with donor agencies. The health sector appears not to be marginalised⁴ in situations where a country has aligned its priorities and strategic plans for pro-poor service delivery in line with a PRSP, where specific targets related to health care financing and delivery have been set, and process and outcome indicators are available for monitoring progress. It is essential that such monitoring actually occurs, rather than being a theoretical possibility. It is also important that civil society plays an active role in the monitoring process.

While some donor agencies such as DFID are focusing on general budget support, recent global initiatives like the President's Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund for AIDS, TB and Malaria (GFATM), which hope to provide funding of US\$10-16 billion annually and US\$3 billion for 5 years respectively (Berman, 2004), may be re-introducing vertical approaches to donor funding. Despite the move towards SWAs and GBS by some agencies, many donors still prefer to provide finances conditional upon the finances being directed to specific programs, or what Berman refers to as 'international priorities' such as the MDGs. This may have a positive or a negative impact on the health sector of affected countries. External funding for specific priorities relieves the burden on the state, but may result in long term capacity deficiencies within government generally and the health system specifically in responding to these critical problems. External funding specifically directed at health sector priority areas such as HIV/AIDS and TB may effectively replace government spending and result in entrenching decreased levels of internal funding of these services which may be politically impossible to increase when external funding is reduced. At present, there is a dearth of empirical evidence on the extent to which these global initiatives⁵ reinforce vertical approaches and their impact on health system functioning.

In summary, many African countries remain heavily dependent on donor funding for health services. There have been two divergent trends in recent years, with increased co-ordination of donor funding and pooling of donor funds with those of government on the one hand and the re-introduction of programmatic donor funding for 'high priority' disease interventions on the other hand. While donor funding will continue to be an important source of health care funding for the foreseeable future, there is a growing urgency in the search for sustainable and equitable domestic sources of finance, not least of all due to the unpredictability of donor funding.

4.3 Out-of-pocket payments

Out-of-pocket payments take two major forms, namely user fees for public sector health services and direct payments to private sector providers. User fees have been the major focus in health care financing debates in Africa and thus are considered in some detail here.

4.3.1 Brief overview of user fees: history, objectives and impact

There were two major contributory factors to the rapid growth in explicit policies of charging user fees for government health services in African countries. Firstly,

⁴ Examples include HIPC countries with GBS such as Uganda, where the focus is on pro-poor spending and delivery based on the specifications agreed upon in the PRSP.

⁵ Rotary International's commitment to polio eradication is an additional example of these global initiatives committed to providing financial support for specific disease priorities.

various international organisations vociferously advocated for the introduction of user fees (Akin et al., 1987, de Ferranti, 1985, Jimenez, 1987). The World Bank and International Monetary Fund were in a particularly strong position to influence policy in African countries as user fees and other cost recovery mechanisms were often an integral part of these institutions' loan conditionality and associated Structural Adjustment Programmes (SAPs). Secondly, macro-economic difficulties in many countries (related to low or negative economic growth and increasing indebtedness) limited the resources available to government for financing and providing health services and led to financing strategies that increasingly placed the burden on service users (Bennett, 1992, Gilson and Mills, 1995).

From the perspective of national governments, two objectives were most frequently cited when introducing or increasing user fees. These were revenue generation and improvement in quality of public sector health services, particularly through availability of medicines at facilities (Nolan and Turbat, 1995). It was anticipated that user fees would generate significant revenue to cover the health care financing gap facing government health services in African countries. Another objective that was set in some countries was to enhance community involvement in the management and 'taking ownership' of local facilities.

International organisations which favoured user fees as a cost-recovery mechanism suggested there were a host of other 'benefits' of fees. These included the idea that user fees prevent unnecessary or frivolous health service utilisation and send 'price signals' to patients about the cost of services at different levels of care and thereby promote appropriate use and adherence to referral mechanisms (Akin et al., 1987, de Ferranti, 1985). They also argued that providers are more likely to be responsive to patients' needs and concerns and to provide good quality care when patients are paying for services. Finally, it was suggested that fees would promote equity in that those who could afford to pay would ease the burden on government who could then concentrate its resources on the poor.

However, the experience of user fees in African countries has been dismal relative to these objectives. For example, fees have on average tended to generate revenue of less than 5 percent of total operating costs (Creese, 1991), although they may cover a sizeable proportion of *non-salary* operating costs (Creese and Kutzin, 1995). When the collection and other fee related administration costs are taken into account, *net* revenue is even lower. The evidence also highlights that the introduction or increase in fees usually leads to dramatic declines in health service utilisation (e.g. of two-thirds in Ghana, over 50% in Kenya, and by a third in Zambia), particularly for the most vulnerable groups (Blas and Limbambala, 2001, Frankish, 1986, Hussein and Mujinja, 1997, Kipp et al., 2001, Mwabu et al., 1995, Waddington and Enyimayew, 1989, Waddington and Enyimayew, 1990). While some argue that user fees will mainly prevent *unnecessary* or *frivolous* health service utilisation, this argument does not recognise that the use of health services is seldom costless. Time, transport costs and other costs of obtaining health care can be significant, which will already deter 'unnecessary' utilisation (Abel-Smith and Rawal, 1992). There appears to be little or no explicit targeting of revenue receipts to extend and improve services for the poor. As noted by Gilson *et al* (1995: 380), who conducted an extensive literature review, "no study was found which directly assessed whether fee revenue use has disproportionately benefited the poor or the nature and extent of cross-subsidies within user fee systems". The African experience also demonstrates that exemption mechanisms, particularly those aimed at protecting the poor, are frequently ineffective (Gilson et al., 1995, McPake et al., 1992, Willis and Leighton, 1995). The Ghanaian experience summarised in Box 1 exemplifies problems with exemptions found throughout Africa.

Box 1: Fee exemptions in Ghana

There are a range of official exemptions in Ghana, including specific services (those for major communicable diseases, immunisations, antenatal and post-natal care) as well as certain services for specified demographic and socio-economic groups (children under five years, pregnant women, the elderly/people above 70 years and 'paupers'). Most importantly, the Ghanaian government has an explicit mechanism for funding exemptions in that facilities can submit a statement of fee revenue 'lost' through exemptions and request reimbursement. This is a major innovation as exemptions are 'unfunded' in most countries, leaving health care providers with weak incentives to exempt patients from fees.

Despite having a relatively comprehensive policy, there is considerable evidence that the exemption policy is poorly implemented. For example, one study in the Volta region of Ghana found that 84% of patients who were eligible for exemptions did not receive them (Nyonator and Kutzin, 1999). A more recent national study found that almost half of the clients interviewed who were eligible for exemptions had in fact paid for services (Garshong et al., 2002). Research has also highlighted that the poor very seldom receive exemptions while the demographic categories (under-fives, elderly and pregnant women) are more frequently exempted (Adams et al., 2002).

Several factors contribute to the lower than desirable effectiveness of exemption implementation practice (Garshong et al., 2002). One factor is the lack of clarity among health service providers about the exemption policy (who is exempted and for which specific services). Another factor is that certain patient categories, such as pregnant women, are easier to identify than others. While there are sometimes difficulties in establishing the exemption eligibility of patients on the basis of age, the most serious problem relates to identifying 'paupers'. There are also obstacles on the health service user side. A national survey of patients found that while most patients knew of the policy, the level of awareness of specific exemption categories was poor. Of even greater concern is that many patients who are aware of their eligibility for exemption sometimes do not exercise their rights due to fear of negative confrontations with providers. Barriers to seeking and obtaining exemptions are likely to be particularly severe for the poor given the stigma attached to applying for 'pauper' status in a crowded health facility. Finally, insufficient funds have been set aside for exemption reimbursements and there are often lengthy delays in disbursing these funds.

4.3.2 Household level consequences of fees

The limited revenue generating potential and adverse utilisation consequences of fees, as well as the ineffectiveness of exemption mechanisms in protecting the most vulnerable groups, have been extensively documented in African countries, particularly since the early 1990s. A more recent focus has been the consequences of charging users for public sector health services at the household level, both in terms of treatment seeking decision-making (whether or not one seeks care when ill and which providers are used) and their effect on household livelihoods.

In South Africa, a national household survey of health needs and health care affordability, conducted just after the introduction of free care services for young children and pregnant women, showed that 22 percent of African interviewees reported having been refused treatment on the grounds of being unable to pay. Approximately 54 percent of unemployed Africans, and 18 percent of white-collar workers reported not seeking treatment as they felt unable to pay for it (Hirschowitz and Orkin, 1995). A survey in Tanzania among individuals who had used health services in the preceding four weeks indicated that 84 percent of rural dwellers found it either difficult or very difficult to find money for health service utilisation, while 81 percent of urban dwellers experienced similar problems (Abel-Smith and Rawal, 1992). A more recent study in one rural district in Tanzania found that 73% of the poorest households cited lack of funds as the reason for not seeking care for a reported chronic illness, while none of the richest households reported being unable to afford health care for chronic illness (Save the Children, 2005). The 1994

Demographic and Health Survey in Zimbabwe indicated that 42% of the urban poor and 14% of the rural poor cited inability to afford health care fees when indicating why they had not sought care for an illness they reported experiencing in the previous month (Bitrán and Giedion, 2002). In Burundi, 34% reported not seeking care due to lack of funds (Bate and Witter, 2003) and in a rural district in Ethiopia, over two-thirds gave this as the reason for not seeking care (McIntyre et al., 2005). Similar results have been found in many other African countries and demonstrate that user fees create a major barrier to accessing health care when needed, particularly for the poor.

For those who do seek health care when they are ill, the direct costs of obtaining such care can account for a substantial proportion of households' income. Payments for health services and medicines accounted for an average of 4-5% of household incomes in the African countries included in one study (Makinen et al., 2000). When other direct costs associated with obtaining care (such as transport costs) are included, some studies have found that total direct costs can be as high as 10% of household income (Lucas and Nuwagaba, 1999). The direct costs of long-term fatal illness, particularly AIDS, have the most devastating effects on households. A study in Tanzania has estimated that the direct costs of treatment for a person living with AIDS during a six month period is about 64% of per capita household income for the same period (Tibaijuka, 1997). There is consistent evidence that the heaviest burden of health care costs, particularly those that are considered catastrophic, falls on the poorest households (Xu et al., 2003). For example, a study in Malawi found that the cost of malaria to households was over 7% of their income on average, but for the poorest households, these costs were as much as a third of their income (Ettling et al., 1994).

One of the first strategies of coping with the costs of illness is to try to avoid these costs altogether "by modifying illness perception (the phenomenon of ignoring disease)" (Sauerborn et al., 1996). The poor often delay seeking care until an illness is severe, which may ultimately lead to higher costs of treatment (e.g. if the person has to be admitted to hospital). Self-treatment using allopathic or traditional medicines available at home, or purchased from a drug seller or traditional healer at a relatively lower cost than at public facilities (and sometimes on credit), is another frequent strategy for avoiding or at least minimising costs (McIntyre et al., 2005, Save the Children, 2005). Where costs are incurred, households use coping strategies such as reducing consumption (including of basic necessities), selling assets and borrowing (McIntyre et al., 2005). A recent study in Ethiopia found that households which had used available cash to pay for health care had intended to use the money for basic consumption needs including food, fuel, clothes and education (Russell and Abdella, 2002). Assets sold may include those that are essential to the household's future livelihood such as livestock and land. Borrowing to cover health care expenses is extremely widespread in Africa, and while some are able to access loans from family and friends at low or no interest, others have to accept loans at ruinous interest rates. A survey in Tanzania found that 40% of respondents had borrowed money to pay for health services used in the preceding four weeks (Abel-Smith and Rawal, 1992). Another study found that between 25% and 49% of respondents in surveys in Kenya, Uganda, Nigeria, Guinea and Burundi borrowed money from family and friends to pay for health services (McPake et al., 1993). In Burundi, levels of borrowing to cover health care costs were found to be 35% in the poorest quintile (Bate and Witter, 2003); in Khartoum, Sudan they were 57% on average for all groups (Witter, 2005); and in a Tanzanian rural district were 63% in the poorest group and 43% in the richest group (Save the Children, 2005). As McPake *et al* (1993: 1391-1392) have noted, "the evidence suggests that when ill, most people seem to find amounts of money which appear large in relation to their regular

incomes. This is probably a tribute to the informal risk sharing mechanism of the extended family and other community support mechanisms. Nevertheless, it highlights the plight of those who fall through this safety net for whom even charges for very basic care may be prohibitive.”

There is growing international evidence that health care costs may plunge households into poverty and that the likelihood of a poor household ever being able to move out of poverty diminishes when confronted with illness-related costs (Whitehead et al., 2001). Recently, the WHO has estimated that 100 million people become impoverished by paying for health care each year and that a further 150 million face severe financial hardship from health care costs (World Health Organisation, 2005). While household impoverishment through health care costs is particularly related to catastrophic illness, even routine ambulatory care with so-called nominal fees can worsen the situation of extremely poor households.

The available evidence on the impact of illness and health care costs at household level clearly demonstrates that the most vulnerable households face enormous constraints in accessing care when they are required to pay user fees, particularly where geographic access is poor and other costs of treatment seeking are high (e.g. for transport). With the high levels of poverty throughout Africa, household livelihoods are so fragile that if a member does have to use health services and pay fees at the time of service use, the household may have to take actions to access cash that could lead to further impoverishment.

4.3.3 Reversing user fee policies

The evidence about the adverse consequences of user fees for household livelihoods is so overwhelming that even the arch protagonist of user fees in the 1980s and 1990s, the World Bank, has acknowledged that “Out-of-pocket payments for health services – especially hospital care – can make the difference between a household being poor or not” (Claeson et al., 2001) and indicates that alternative financing mechanisms such as insurance may be preferable. Another institution that has historically supported user fees, the US government, in its 2001 foreign appropriations bill report requires the US Congress to oppose any World Bank, IMF or other multilateral development bank loan which includes user fees for basic health or education services, and to report to Congress within 10 days if any loan or other agreement is approved which includes such fees (US Network for Global Economic Justice, 2003).

Even though it is encouraging that the key International Financial Institutions (IFIs) that have historically insisted that African countries levy user fees for public sector health (and other social) services are changing their position, and that there is increasing explicit international advocacy for the removal of fees (e.g. by Save the Children and the British government), the challenge of reversing fee policies is enormous. Some African countries, most notably South Africa and Uganda, have already abolished all or some user fees and their experience provides some useful insights.

South African experience of fee removal

South Africa was one of the first countries to initiate fee removal, which has occurred in two phases. The first phase involved the removal of fees for all health services at all public sector facilities for pregnant women and children under the age of six years, which came into effect on 1 June 1994. Announced by President Mandela in his first address after the elections (May 24, 1994), this policy was clearly seen to be of major national importance. The second phase was the removal of all fees for primary care services on 1 April 1996.

Although the 'free primary health care' policy has never been comprehensively analysed, there was a detailed evaluation of the first phase of fee removal. This evaluation reported largely positive effects of the fee removal, with health service utilisation increasing substantially and pregnant women started attending ante-natal care at an earlier stage (McCoy, 1996). However, some concerns were raised about the potential for increased curative care utilisation to crowd out preventive care utilisation (Wilkinson et al., 2001).

There were also a number of problems with the implementation of this policy. Firstly, all health workers and managers, with the exception of a few of the most senior national health department officials, first heard about the policy when the President announced it a few days before it was due to be implemented. Thus, there was no time to adequately plan and drug supplies were quickly exhausted as utilisation increased massively. Secondly, the number and proportion of visits at tertiary hospitals by young children and pregnant women that could have been treated at lower levels increased after the removal of fees. This inappropriate use of higher level services was ascribed to the design of the policy, which did not specify that patients had to follow the referral route. Finally, and probably most importantly, there has been a negative impact on health worker morale. There was considerable health worker resentment about the process of introducing the policy, particularly that they had not been consulted or had an opportunity to plan for its implementation (McCoy, 1996, Walker and Gilson, 2004). The lack of communication, particularly about the reasons underlying it, has resulted in health workers and lower level managers forming their own opinions, frequently negative, about the value of this policy (McIntyre and Klugman, 2003). Health workers indicated that the policy exacerbated poor working conditions, particularly overcrowding and staff shortages at health facilities. In particular, frontline health workers feared that patients would abuse this policy, with some arguing that it "would encourage women to become pregnant", although there is no empirical evidence that this has occurred (McCoy, 1996).

As indicated previously, the removal of fees from all public sector primary care services has not been evaluated systematically to date. However, analysis of a panel household survey dataset in one rural province showed quite large increases in the use of public sector primary care facilities after this policy, although the increase was below average for the poorest group (Personal communication – Dr Jane Goudge, Centre for Health Policy).

Ugandan experience of fee removal

Uganda introduced user fees on a universal basis in 1993, in order to meet a World Bank loan conditionality (Okunzi, 2004). Although revenue generation was relatively low (generally less than 5% of expenditure), it was an important source of funds for supplementing health worker salaries, maintaining facilities and purchasing additional drugs (Burnham et al., 2004). However, there were growing concerns about the consequences of user fees, particularly for the poor. In 1999, a Participatory Poverty Assessment highlighted the extent of the impact on the poor and the level of grassroots dissatisfaction with the policy (Okunzi, 2004, Yates, 2004).

User fees at public sector facilities were abolished in March 2001, with the exception of private wards (Yates, 2004). Various studies have shown that utilisation of health services increased immediately and dramatically. One study of 78 health facilities in 10 districts, using data for 8 months before and 12 months after the removal of fees, found that the mean monthly number of new visits increased by 53%, although in the case of children <5 years of age the increase was only 27%, while repeat visits

increased by 24% overall but by 81% for children <5. Although immunisations, antenatal services and family planning had always been free, utilisation of these services also increased (by 17%, 25% and 32% respectively) after the removal of fees (Burnham et al., 2004). Two years after the abolition of fees, sustained utilisation increases of 77% were recorded (Yates, 2004).

An extensive study using the first and second Ugandan National Household Surveys (conducted in 1999/2000 and 2002/03 respectively) and data from the Health Management Information System highlighted that the poor had particularly benefited from the removal of fees (Deininger and Mpuga, 2004). Although the incidence of reported illness in the previous 30 days was similar in the two surveys (of slightly less than 30%), the percentage of those who were sick who sought professional care increased from 69% to 79% and the number of days when the sick person was unable to work declined from 8.3 to 7 days on average. In addition, 30% of those who did not seek care cited inability to afford health care as the reason in 2002/03 compared to 50% in 1999/2000. The poor benefited most from the abolition of fees; utilisation of health services when ill increased from 58% to 70% in the case of the poorest quintile and from 80% to 85% for those in the richest quintile. A key finding of this study was that although there were substantial differences in use of health services when ill between the rich and the poor while fees were in place, these differences were completely eliminated in the case of children (but not in the case of adults) after the removal of fees. Given that the removal of fees does not eliminate all costs of illness and treatment seeking, such as transport to a facility and time lost to productive activities, the above finding suggests that in the poorest households children will be taken to a health care facility when ill whereas adults will avoid seeking treatment if possible so as to avoid non-user fee direct costs and losing productive work time to seek care.

A number of the studies have highlighted that these sustained utilisation increases, and related positive outcomes such as national immunisation coverage increases from 41% in 1999/2000 to 84% in 2002/03 (Yates, 2004), could not have been achieved without an increase in the resources available for public sector health services. Of particular importance was the pro-active provision of a \$5.5 million buffer fund by the Ministry of Health to offset the potential impact on availability of drugs arising from the loss of fee revenue and utilisation increases (Burnham et al., 2004). In addition, the move away from project-specific donor funds to the pooling of donor funds with Ministry of Health funds under a SWAp initiative resulted in the Ministry budget doubling in real terms between 1999/2000 and 2002/03. The Ministry has control over the allocation of these SWAp resources and has directed the additional resources preferentially to primary health care services; district budgets have increased seven-fold since 1999/2000 (Yates, 2004). The important role of donor funding (and one large donor in particular) in facilitating the removal of user fees in Uganda should be recognised, not least of all because of the potential difficulties of sustaining this level of district budgets if one or more donors should decide to withdraw their health sector support in Uganda.

While there is overwhelming evidence of the substantial positive consequences of fee removal in Uganda, particularly for the poorest, there have been some negative consequences. Of particular concern is the decline in staff morale (Burnham et al., 2004). This is related to the loss of fee revenue which had previously been used to supplement staff salaries, as well as the fact that workload had increased by about 47%. Health workers and members of the health facility management committees also indicated that maintenance of health facilities and cleanliness had declined. It should be noted, however, that these findings were obtained in the twelve months

after the fee removal. The more recent substantial increases in primary care facility budgets may have improved staff workload ratios.

Key issues arising from the experience of user fee removal

All of the information from the two African country experiences of user fee removal indicates that abolishing user fees for at least some health services has reduced financial barriers to access and resulted in immediate and dramatic service utilisation increases. In some cases, this has been shown to particularly benefit the poor, but in other cases there are remaining barriers to access (such as geographic distance and associated time and transport costs) that limit the extent to which the poor are able to benefit. Thus, fee removal should be seen as only one component of a comprehensive package to improve the availability, affordability and quality of public sector health services (Gilson and McIntyre, 2005).

The African experience of fee removal to date also clearly demonstrates that fee removal cannot occur overnight. There is a need for careful planning and for improved resource availability if fees are removed, not only to offset any fee revenue lost (which is frequently very low), but more importantly to continue to provide adequate quality services in the face of increased utilisation. Plans for increased drug supplies are particularly important, and it is critical to monitor staff workloads and to address staff shortages where they arise. It is also essential to adequately communicate with frontline health workers, to explain the reasons for fee removal and to promote their support for the policy, as well as to fully inform the general public of changes in fee policies (Gilson and McIntyre, 2005).

Remaining concerns about fee removal

Some African countries are seriously considering the removal of some or all user fees, while others remain convinced that fees are a 'necessary evil'. There are anecdotal indications that in some cases, unwillingness to even consider removing user fees is linked to resistance to 'imperialist' interventions. African governments were in most cases forced by international organisations to introduce user fees, often as part of structural adjustment programs, a few decades ago. Now international organisations are attempting to impose their preference for removing user fees. It is unsurprising that some governments are resisting this latest attempt by international organisations to exert influence over domestic policies. It is for this reason that Gilson and McIntyre (2005) called "for sensitivity in how international donors and agencies approach African countries on the issue of fee removal".

Another concern expressed by African countries that are under pressure from international organisations to remove fees is that there will be 'excessive' use of health services that are free at the point of use. To some, this may appear to reflect one of the initial arguments in favour of imposing fees, namely that it will reduce 'frivolous' use. To others, it is simply a case of recognising that as African health systems suffer from a serious shortage of skilled health personnel, drug supplies and other resources, any increase in utilisation will further overextend existing services. As indicated previously, there is consensus that if fees are removed, additional health care resources must be made available to avoid these consequences (and other sections of this paper critically review how one may generate these additional resources). The key question to consider is whether the increased utilisation that will result from the removal of fees represents previously unmet need or reflects unnecessary use (recognising that patients incur some costs other than fees in accessing services).

We are of the view that the increased utilisation that will arise is very largely related to previously unmet need. There is considerable evidence from household surveys

that many do not use services despite suffering from chronic illnesses and severe acute illnesses. In addition, utilisation levels in most African countries are extremely low; in many countries it is less than 1 health care visit per person per annum. For example, the national average utilisation of primary care services in Rwanda in 1999 was only 0.2 visits per person per year (Schneider and Diop, 2004). A 'normative' estimation of appropriate health service utilisation levels was undertaken in South Africa, based on the burden of disease and need for preventive services (e.g. incidence of tuberculosis and sexually transmitted diseases, pregnancy rate, number of young children requiring immunisations etc. and number of visits required in each instance). The initial estimate in the mid 1990s was that there should be an average of 3.5 visits per person per year to appropriately address the primary health care needs of South Africans (Rispel et al., 1996). This was revised last year to take account of the increased need for HIV/AIDS related treatment and is now estimated to be 3.85 visits per person per year. While this level of expected utilisation is based on a relatively comprehensive primary care service package, it is not unrealistic. For example, almost every district in Botswana reports at least 4 visits per year to public sector facilities per capita (Bloom and Lenneiye, 1989).

Unfortunately, the debate about 'excessive' versus 'needed' health service utilisation has become a heated one, with little clear evidence. Two actions may contribute to reaching some conclusion to this debate in order that individual countries can make well-informed decisions on whether or not it is appropriate to remove fees. Firstly, it may be helpful for countries to estimate what an appropriate primary health care utilisation rate would be within the context of their burden of disease and other indicators of need for primary care services. This can then be compared with current national average utilisation rates to assess whether utilisation is at 'acceptable' levels or whether there is a clear indication that there is unmet need. The normative level should also be compared with household survey data on utilisation rates across different socio-economic groups to assess whether the poorest groups (who usually bear the greatest burden of ill health) have appropriate utilisation levels relative to this norm. Such utilisation 'norms' (or target utilisation rates) are also extremely helpful in estimating the additional resources that would be required if utilisation increased to the target rate and to identify specific geographic areas (e.g. health districts) that are in particular need of additional resources to increase utilisation rates to appropriate levels. Secondly, it is necessary to provide accurate empirical evidence on what is referred to as unnecessary or excessive use of health care services in order to understand the magnitude of the problem and identify alternative ways of addressing any problems identified (to avoid the danger of fees preventing unmet need being met). It may be that this 'excessive' use is related to relatively 'minor' ailments. This may require community education, but it should be borne in mind that most patients are not in a position to assess whether symptoms are serious or whether they can be ignored safely and that people are unlikely to incur the frequently heavy time costs of seeking care at public sector facilities for trivial ailments (Abel-Smith and Rawal, 1992). In South Africa, research at primary care facilities indicated that the major burden of 'unnecessary' use of services was related to people requesting a 'sick certificate' to justify not going to work (Personal communication – District Manager in Cape Town Metropole). The solution in this case was not to impose fees on all patients but to simply screen patients and refer those seeking sick certificates to private doctors (as they were employed in the formal sector, they could probably afford this and it relieved the burden on public sector facilities).

In summary, the issue of whether to retain user fees at public sector facilities or to remove them is one of the most critical debates for each African country to explore. We believe that this issue should be widely debated within individual countries, and

that such debate should be evidence-based. In countries where fee removal is agreed upon, careful planning and implementation of the policy is required.

4.3.4 Direct payments to private sector providers

So much attention has been focussed on user fees for public services that the sizeable component of out-of-pocket payments in the form of direct spending on private providers is often overlooked. These providers include both not-for-profit NGOs, particularly mission facilities in the African context, and private for-profit providers. The use of private providers is widespread in African countries, even among relatively low income groups. For example, one comparative analysis of health service utilisation patterns in African, Asian and Latin American countries (based on household survey data) found that, of those who had sought care when ill in the previous 2 weeks, 20% had used a private provider in Zambia while 58% had done so in South Africa. In South Africa, private sector use was heavily concentrated in the higher income groups (83% of the highest income quintile had used private providers compared with 37% in the lowest income quintile) while the variation across income groups was much lower in Zambia (22% in the highest income quintile and 16% in the lowest income quintile) (Makinen et al., 2000).

Mission health facilities play a critical role in many African countries. In some instances, a mission hospital is the only facility in a particular rural area and will then frequently be the designated district hospital and receive government financial support and/or secondment of government health professionals to work in the facility. However, even when there is a strong collaborative relationship between missions and the Ministry of Health, mission facilities tend to receive far less government funding than publicly-owned facilities. They tend to charge higher fees than public sector facilities in order to generate the additional resources that they need, although they may also receive foreign grants to support their activities. The issues raised above in relation to user fees at public sector facilities also apply to mission facilities. The key difference is that mission facilities can only consider removing user fees if they are guaranteed sufficient financial allocations from government or donor sources.

The category of private for-profit providers ranges from doctors and other health professionals working in private practice to informal drug sellers and traditional healers. While utilisation of these services may arise from cultural or other preferences, it should be recognised that not all of this use of private providers is from 'choice'; for example, where a patient attending a public sector facility whose drug supply is finished has to go to a private pharmacy or informal drug seller to access these drugs.

The growth of private sector health care provision and use of private providers has been an explicit policy objective in many African countries. Once again, this policy is linked both to constraints on governments' ability to meet all the health care needs of their populations (related to macroeconomic and budgetary constraints) as well as to the policy prescriptions of IFIs, imposed through loan conditionalities and other coercive mechanisms. Out-of-pocket payments to private providers is not considered in detail here as this requires detailed consideration of the equity implications of the continued commercialisation of health service provision (as opposed to health care financing), other than to note that they are, along with user fees, the most regressive form of financing health services and that strategies for addressing the burden on households of these payments include private sector regulatory mechanisms, improvement of quality of care in public sector facilities and pre-payment financing mechanisms.

4.4 Health insurance

4.4.1 Brief overview of different types of health insurance schemes

As indicated previously, there is very limited health insurance in African countries but it is a health care financing option that is increasingly coming under the policy spotlight. This section provides a brief overview of the different forms that health insurance can take, drawing on the limited experience in Africa as well as the vast experience in Europe, other high-income countries and middle-income countries in Asia and Latin America. One of the key features that distinguish different types of health insurance is whether or not there is a legal requirement to belong to health insurance. *Mandatory* health insurance is a term used to describe insurance systems where there is a legal requirement for certain groups or the entire population to become members, while *voluntary* health insurance is used to describe systems where there is no such legal requirement.

Within the category of mandatory insurance, social health insurance is the term that is generally used to refer to a system where only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from, or are 'covered' by, the insurance scheme. In contrast, the term national health insurance generally refers to an insurance system that is universal, or covers the entire population irrespective of whether they have personally contributed to the scheme or not (e.g. where government fully subsidises the contributions of particularly vulnerable groups). However, it should be noted that this terminology is not used consistently, with social and national health insurance often being used inter-changeably. Mandatory insurance contributions are 'community-rated', i.e. they are based on the average expected cost of health service use for the entire insured group instead of taking an individual's or group's risk of illness into account. Contributions may be a flat rate or may be differentiated by income level and sometimes the number of dependents covered. There may be a single fund or a number of funds that together make up the mandatory insurance scheme. In the latter case, a standardised, prescribed minimum benefit package is usually specified in the enabling legislation. In addition, there is usually a risk-equalisation mechanism which effectively pools the contribution revenue of all of the schemes and individual schemes are allocated an amount which reflects the expected costs of that fund or scheme based on the illness risk of its membership (through a risk-adjusted capitation payment).

Voluntary health insurance has historically referred to health insurance cover that is employment based, i.e. employees in a particular company or industry join a health insurance scheme and the contribution is shared by the employees and employers. Where the insurance is run by a commercial company on a for-profit basis, contributions tend to be 'risk-rated', where each person's or group's insurance contribution is related to the risk of illness or the expected cost of service use (i.e. the elderly and those with chronic conditions pay a higher contribution). However, some voluntary, employment-based insurance groups charge 'community-rated' contributions, frequently because there is a regulatory requirement to do so. A more recent type of voluntary health insurance that is quite widespread in Africa is that of community-based health insurance schemes (also called mutual health insurance, community-based pre-payment schemes or community health funds). These are schemes that exist within localised communities, most frequently in rural areas, where members make small payments (often on an annual basis after the harvest time) to the scheme, which then covers their user fees at health services. They may be initiated by the community themselves, a health facility within the community (e.g. a mission hospital), by central government or by a donor.

Some of the key issues from recent African experience of these different health insurance schemes are raised in the following sections.

4.4.2 Private voluntary employment-based insurance

This form of health insurance has been in existence for many decades (the first one being established in South Africa in 1889 (McLeod, 2005)) in a number of Southern African countries (particularly South Africa, Zimbabwe and Namibia) and is usually referred to as a 'medical scheme'. Medical schemes began as non-profit organisations, as a way for private firms to provide for the health care needs of their employees. Contributions to the schemes were made by both employers and employees and were community rated. Initially, the vast majority of medical schemes were 'closed schemes' in that membership of each scheme was only open to employees of an individual company. This has changed over time (particularly in South Africa and to a lesser extent in Zimbabwe), with schemes becoming 'open', i.e. allowing anyone to join (except in some cases high risk individuals).

The experience with these schemes, particularly over the past few decades, has not been entirely positive. Some of the key concerns, which are illustrated using South African data due to the fact that it is more readily accessible but reflect consistent trends in other countries with such schemes, include:

- They cover a very small proportion of the population (16% in South Africa at present) and have contributed to considerable inequities within the overall health system, whereby a small elite have access to extensive private health services and resources while the vast majority is dependent on under-resourced and over-extended public health services (McIntyre and Doherty, 2004).
- The number of medical schemes has grown dramatically which has fragmented the insured population into a large number of very small risk pools, which has raised concerns about the sustainability of this health insurance mechanism (McLeod, 2005).
- There have been rapid increases in expenditure, particularly in relation to medicines, private hospital admissions and scheme administration activities, and hence in the contribution rates charged, by schemes. There are various reasons why this has happened (e.g. as service providers are paid a fee for each service they provide, there is an incentive for them to 'over-provide'), but the consequence is that medical scheme membership has become increasingly unaffordable (Doherty and McLeod, 2003, McIntyre and Doherty, 2004). During much of the 1980s and 1990s, contributions were increasing at rates far exceeding the general inflation rate while at the same time benefit packages were being reduced. As a consequence medical scheme members found they had to pay a considerable amount of money out of pocket for services that were not, or were only partially covered, by the scheme.
- Limited tax resources are increasingly being devoted to supporting this expensive private insurance system. This occurs in two ways. Firstly, the tax deductibility of medical scheme contributions reduces government tax revenue considerably. In South Africa, this was estimated to be over US\$1 billion in 2001 (McLeod, 2005). In addition, these benefits are inequitably distributed, with higher income earners receiving a much greater share of the tax benefits. Secondly, the largest single employer in most African countries is the government, and a substantial amount of tax resources is devoted to purchasing medical scheme cover for civil servants. For example, the South African government spent 12 times more paying for medical scheme cover per civil servant than it spent on funding public sector health services per person dependent on these services in the early 2000s (McIntyre and Doherty, 2004). This raises serious equity concerns about the use of limited tax funds.

South Africa is the country which has introduced the most extensive legislative and regulatory framework for private voluntary employment-based health insurance in an attempt to deal with some of these concerns. Some of the key legislative and regulatory changes that have been introduced are:

- Ensuring that contributions are community-rated and that no one who applies to a scheme can be refused membership on the basis of being high risk (although there are waiting periods before the member can start claiming benefits) (McLeod, 2005).
- Regulating that every scheme has to provide cover for a 'prescribed minimum benefit package'. This package includes health services that could impose catastrophic costs on members and includes hospitalisation and all services for a wide range of chronic conditions, including AIDS (McLeod, 2005).
- Reforming the tax benefits for medical scheme members. In particular, it is proposed that a maximum cap be imposed on the tax benefit so that everyone contributing to a medical scheme would receive the same subsidy (of about US\$50 per person per month) (National Treasury, 2005). While this would promote a more equitable distribution of the tax benefit, there remain concerns about the amount of government resources being devoted to subsidising expensive private sector cover for a minority of the population (McIntyre et al., 2005).

Medical schemes themselves are introducing changes to their traditional way of operating in order to try to contain costs and to attract more members. For example, they have implemented a number of American-style 'managed care' initiatives, such as insisting that members get permission from their schemes before being hospitalised with the scheme independently assessing the need for hospitalisation and setting limits on the number of days of admission, and using formularies of the drugs considered to be most cost-effective from which health care providers can prescribe and dispense (Doherty and McLeod, 2003). Schemes are also negotiating special rates with certain providers. In particular, some schemes are negotiating with public hospitals to provide care for their members in 'private wards'. While this can bring revenue into cash-strapped public hospitals, there are concerns about the equity implications for public hospitals. Current experience suggests that such mechanisms may end up sucking in resources from, rather than subsidising the care provided in, public wards, and creating a two tier system within hospitals (Wadee and Gilson, 2005).

Further legislative and regulatory changes are envisaged (e.g. the introduction of a risk-equalisation mechanism – see explanation in section 4.4.1), but these are explicitly seen as a mechanism for moving away from private voluntary insurance to a social health insurance. This reflects a growing consensus that in order to address some of the problems that have arisen with voluntary private insurance and to promote greater equity within the insured population as well as in the overall health system, moving towards some form of mandatory health insurance scheme is the most feasible option. Mandatory insurance is discussed in detail in section 4.4.4.

4.4.3 Community-based health insurance schemes

Community-based health insurance (CBHI) schemes (also called mutual health insurance, mutual health organisations, community-based pre-payment, community health funds etc.) take many different forms. They can broadly be defined as "any scheme managed and operated by an organization, other than a government or private for-profit company, that provides risk pooling to cover all or part of the costs of health care services" (Bennett, 2004) and generally include an element of community participation in their management or some form of democratic accountability of the management to the members. Most frequently, these schemes provide cover for

those outside the formal employment sector and often serve rural communities. They may be linked with a particular health service provider (e.g. the scheme may only provide cover for services provided at the local hospital) or may cover services provided at a range of health facilities among which members can choose. These schemes primarily developed as an alternative to user fees, i.e. instead of paying a fee at the time of using a health service, community members make small pre-payments to the scheme which then cover the fee charged for the health services used.

The majority of the oldest and largest CBHI schemes are to be found in Central and West Africa; the widespread development of such schemes in East and Southern Africa is a relatively new development. Key features of some of the more well-known CBHI schemes in Africa are summarised in Appendix D.

These schemes are becoming increasingly popular, with a very rapid growth in the number of schemes operating in African countries (Atim, 1998), many of which have been actively promoted by various international organisations (e.g. the World Bank provided financial and technical support for the establishment of the Tanzanian Community Health Fund). The Commission on Macroeconomics and Health recommended that CBHI be increasingly used as a mechanism “to help cover the costs of community-based health delivery” in poor communities (World Health Organisation, 2001). Similarly, the World Bank focuses almost exclusively on community insurance in its book on “Health Financing for Poor People” (Preker and Carrin, 2004). There is a concern that some of these international organisations may view CBHI as the new ‘one size fits all answer’ to health care financing challenges in African countries. It is also of concern that CBHI is being widely promoted despite the fact that, as noted by a recent extensive review of research on CBHI, “the evidence base is limited in scope and questionable in quality” (Ekman, 2004). While there is a rapidly growing literature on these schemes, much of the research has focused on individual schemes and particularly on management capacity issues. Surprisingly little *detailed* research has been published that address questions such as ‘what works and what doesn’t work, why and in what context’.

While there is clear evidence that these schemes may provide financial protection against unexpected health care costs for their members, and improve access to services when needed (Schneider and Diop, 2004), there are a number of concerns about this form of financing. The primary concerns relating to CBHI include:

- They generate a relatively limited amount of revenue, with one study finding that on average, about 25% or less of the costs of providing health services are recouped through CBHI contributions. This is certainly significantly higher than cost recovery levels through user fees and is an important source of revenue for local health services. Nevertheless, it highlights the fact that CBHI can never be more than a supplementary source of health care financing and that the majority of funding for health services in poor communities will need to continue to come from another source for the foreseeable future.
- With very few exceptions, the level of population coverage by these schemes is relatively low. Even well established schemes such as the CAM scheme in Burundi, the Babouantou scheme in Cameroon and the Nkoranza scheme in Ghana cover a quarter or less of the community or target population (Ekman, 2004). The Bwamanda scheme in DRC has a uniquely high coverage level of about 60% of the community (Criel et al., 1999). The majority of schemes have far lower coverage levels, such as 2.8% in one of the earliest Tanzanian Community Health Funds (Chee et al., 2002) and 6% in the Maliando scheme in Guinea (Criel and Waelkens, 2003).

- There is evidence that CBHI reaches “a large number of low-income populations who would otherwise have no financial protection against the cost of illness” (Jakab and Krishnan, 2004). Nevertheless, such schemes that focus on rural communities or informal sector workers in urban areas do place a burden on those with the least ability to pay, and may end up being a mechanism whereby “the poor simply cross-subsidize the health care costs of other poor members of the population” (Bennett et al., 1998). There is also overwhelming evidence that the poorest and most vulnerable groups are excluded from these schemes (Ekman, 2004, Jakab and Krishnan, 2004). Affordability of even relatively low contributions has been shown to be a constraint to expanding coverage in some schemes (Criel and Waelkens, 2003).
- A related issue is that the poorest community members will only be incorporated in these schemes if their membership contribution is partly or fully subsidised. While there are some examples of contributions being subsidised either by the scheme itself (i.e. out of other members’ contributions) or by government or donors, considerable challenges are faced in identifying the most vulnerable households to benefit from these subsidies. In addition, a mechanism for allocating government and/or donor funds equitably between schemes is needed, whereby greater amounts are allocated to communities with the highest poverty levels. The equitable use of limited government and donor funds to support these schemes is a critical issue. In some countries, such as in Tanzania for the Community Health Fund, government and donor funds are used to provide ‘matching grants’ according to the amount of revenue generated by each scheme. While this is intended as an incentive for the scheme to register as many members and generate as much scheme contribution revenue as possible, it does mean that areas with lower poverty levels, which are likely to be able to generate the largest contribution revenue, are generally able to secure the largest share of subsidies from government and donor funds, raising serious equity concerns. There is growing debate about whether CBHI schemes are the most appropriate way to ensure access to health care for the vulnerable (this is touched on further in a later section).
- Very little attention has been paid to how CBHI schemes link with other components of the health system (e.g. the impacts on non-members of schemes, linkages with direct government spending on services, impact of government subsidies to schemes, etc.) (Bennett, 2004). Given that these schemes will always be only one component of health care financing within any particular country, it is important to explore how such schemes contribute to (or detract from) overall health system equity.

There is a clear need for additional research to determine how to extend coverage of these schemes, how to ensure that the most vulnerable households are not excluded from the schemes and how these schemes could best contribute to an equitable health system. Research documenting the experience of these schemes to date has highlighted some factors that can promote the successful implementation of these schemes. These include:

- Social factors were also found to influence enrolment levels. For example, Arhin (1995) suggested that ‘social cohesion’ is an important reason for the near universal participation in the Abota scheme in Guinea-Bissau. Other authors have noted the important role of community leaders in persuading community members to join and remain in schemes (Eklund and Stavem, 1996).
- The affordability, frequency and timing of scheme contributions is an essential aspect of a successful scheme (Arhin, 1995, Eklund and Stavem, 1996, Shephard et al., 1996, Jakab and Krishnan, 2004, Shepard et al., 1996). Most successful rural schemes collect contributions once or twice a year, timed to coincide with harvests and sometimes allow payment in kind. A sliding contribution scale,

rather than a single flat rate contribution, can promote affordability to households with a wider range of income levels (Bennett et al., 1998, Atim, 1998). Another issue of importance is whether the contribution is made on a per person or per household basis, with those with a larger family size finding it difficult to cover all of their members if per person contributions are charged. Many schemes are addressing this problem by using a graduated fee, where the fee per person declines as family size increases (e.g. a 4 person household may pay \$1 per person, while a 6 person household may pay \$0.80 per person) (Personal communication – Dr Chris Atim).

- A related issue is the need for government support to ensure sustainability and equity in the scheme (Jakab and Krishnan, 2004), which may include creating the necessary legal framework for schemes and providing technical support (Bennett et al., 1998) as well as funding to subsidise members exempted from contributions.
- Successful schemes have also instituted mechanisms to reduce the potential for adverse selection (i.e. the highest risk individuals with the greatest need for health services joining the scheme). In most cases, enrolment is only permitted at one time during the year, usually at the time of harvest when contributions are paid (Arhin, 1995, Shephard et al., 1996, Lambo, 1998). In contrast, schemes such as the CAM card scheme which permit enrolment at any time during the year, have been found to be subject to significant adverse selection (Arhin, 1994). Another mechanism for reducing adverse selection is to require family, as opposed to individual, membership (Lambo, 1998, Shephard et al., 1996, Atim, 1998).
- The proximity of the health facility which will provide services covered by the scheme also influences willingness to pay scheme contributions (Arhin, 1995, Shephard et al., 1996). In addition, the perceived quality of services covered by the scheme is of critical importance (Arhin, 1994, Chabot et al., 1991, Criel and Waelkens, 2003). For example, Shaw and Griffin (1995) noted that the Bwamanda hospital was regarded as having a high quality of care (and achieved high coverage levels), but that the same did not apply in the CAM card scheme (which has relatively low coverage levels). Most community members cited drug shortages at health facilities as the major reason for not participating in the CAM card scheme (Arhin, 1994, Shaw and Griffin, 1995). A related issue is the need to consult the target population when designing the scheme's benefit package to determine their preferences and needs (Bennett et al., 1998).
- There should be active purchasing of health services for scheme members so as to negotiate reasonable prices, ensure services in the benefit package are available and to monitor quality of care (Bennett et al., 1998, Jakab and Krishnan, 2004).
- Another characteristic of successful schemes is the existence of adequate capacity to manage funds (Eklund and Stavem, 1996). As contributions are usually made once or twice a year, it is important that funds be invested in interest bearing accounts (Shepard et al., 1996, Bennett et al., 1998, Shephard et al., 1996). In addition, there should be a committed and accountable community-based management committee (Jakab and Krishnan, 2004) that is trusted by the contributors (Schneider, 2005).

There is also some evidence that the processes of implementation have important influences over the impact of such schemes (Goudge et al., 2003, Kamuzora, 2005).

Although there is a need for further research and there are many challenges that need to be addressed if CBHI is to play a substantial role in equitable health systems, they are seen as an important way of providing some form of financial protection, to supplement general tax and donor resources, for those outside the formal employment sector. A critical issue to make allowance for at an early stage is

how CBHI schemes are to be integrated into the overall health system, which includes considering a degree of consistency in their design (e.g. contribution levels and benefit packages). While it is seen as important that each CBHI scheme is designed to meet the needs of the community within which it is located, this makes it difficult to integrate schemes into a coherent pre-payment system at a later stage (Bennett et al., 1998). One country that has taken an interesting approach in this regard is Ghana, whose health insurance proposals are considered in the following section.

4.4.4 Mandatory health insurance

A few African countries have for some time had mandatory insurance systems that include health benefits, particularly in West Africa (e.g. Cameroon, Côte d'Ivoire and Senegal) and to a lesser extent in East Africa (e.g. Burundi and Kenya) (Kutzin, 1998). However, such schemes cover no more than 5% to 10% of the employed population in SSA (Reynaud, 2002) and there is very little literature critically evaluating these schemes. There has been limited interest in mandatory insurance exclusively for the health sector (as opposed to mandatory insurance for a comprehensive set of social security benefits) in the African region until very recently. A number of African countries have either recently introduced, or are seriously considering introducing, some form of mandatory health insurance (MHI). This section provides a brief overview of these initiatives in four countries, namely:

- Tanzania, which recently introduced a social health insurance scheme (SHI) (i.e. covering only certain groups);
- South Africa, which has been debating and planning for the introduction of a SHI for over a decade;
- Ghana, which has already begun introducing a national health insurance (NHI) scheme (i.e. covering the entire population); and
- Kenya, which has developed detailed proposals for the introduction of a NHI.

Tanzania

In 1999, Tanzania enacted legislation to introduce mandatory health insurance for all civil servants and their dependents (spouse and up to 4 children or other legal dependents) (Government of Tanzania, 2001). This 'National Health Insurance Fund' (NHIF) scheme was initiated on 1 July 2001, and initially only covered central government employees but was extended to all civil servants in 2002. It has enrolled over 1.1 million beneficiaries to date, which is equivalent to approximately 3% of the Tanzanian population (Ministry of Health, 2005).

Monthly contributions are equivalent to 6% of employees' gross salary, half of which is paid by the employer and 3% by the employee. Contribution revenue is equivalent to approximately 6% of government spending on health services (Ministry of Health, 2005). The benefit package covers outpatient and inpatient services provided at accredited providers and drugs included on the essential drug list. Services that are explicitly excluded from the package include: prosthetic appliances; attempted suicide related care; drug or alcohol abuse related illnesses; occupational injuries and diseases; circumcision and cosmetic surgery (Government of Tanzania, 2001). In terms of health facility accreditation, all public health facilities were automatically accredited in 2001. Thereafter, certain mission and NGO facilities were accredited and finally, private-for-profit facilities are in the process of being accredited. Accredited providers are paid on a fee-for-service basis.

It was always intended that mandatory health insurance coverage would be extended to formal sector employees of private firms. This is about to be implemented under the auspices of the National Social Security Fund (NSSF). This fund provides a

range of social security benefits and will now include a 'Social Health Insurance Benefit'. The design of the scheme is very similar to that for civil servants (contribution rate, benefit package etc.). The main difference is that providers will be paid on a capitation rather than fee-for-service basis.

Possibly the most surprising aspect to the development of mandatory insurance in Tanzania is the creation of separate insurance funds for civil servants and private sector employees. This will reduce the extent of risk pooling that would be possible among formal sector employees and their dependents.

South Africa

The possibility of introducing a SHI has been under discussion in South Africa since the early 1990s. Indeed, the African National Congress which came to power in the first democratic elections in 1994, incorporated explicit recommendations for a Social Health Insurance (SHI) in its National Health Plan (African National Congress, 1994) and the option of a SHI was further explored in two government established health care financing committees in 1994 and 1995. These initial proposals were primarily seen as a mechanism for addressing the uncontrolled cost spiral in the private voluntary health insurance (termed medical schemes) and to address the inequitable public-private health system mix inherited from the apartheid era, i.e. to improve overall health system equity (McIntyre et al., 2003)⁶. Instead of pursuing SHI in the mid-1990s, it was decided to attempt to address some of the problems with medical schemes through direct government regulation (see section 4.4.2). This was seen as a critical preparatory phase to improve the efficiency of voluntary insurance before insurance coverage was made mandatory (McLeod, 2004).

The future process for introducing SHI in South Africa is seen as involving three steps:

- Improving risk-related (i.e. healthy to ill) cross-subsidies;
- Ensuring income-related (i.e. high- to low-income) cross-subsidies;
- Introducing mandatory cover (McLeod, 2004).

The first step in the process, namely the introduction of a risk-equalisation mechanism, was approved by Cabinet in early 2005. The risk-equalisation fund (REF) will effectively transfer resources from schemes which have a low-risk membership to those that have a relatively high-risk membership. The risk factors that will be taken into account are: age of members in each scheme; a maternity delivery indicator; the number of people with specified chronic diseases in each scheme (both single and multiple chronic diseases); and the number of people in each scheme with HIV who are receiving anti-retroviral treatment (McLeod, 2004). At present, data on each of these indicators is being collected from each scheme and the REF will be fully implemented by 2007.

The second step of introducing income cross-subsidies is currently under discussion. It is envisaged that the current subsidy on medical scheme contributions, through tax deductibility of scheme contributions will be removed. As indicated in section 4.4.2, higher income members of medical schemes receive a higher subsidy than lower income members. In addition, and more concerning, the majority of medical scheme members receive a greater subsidy through this tax deduction than the government spends per person dependent on publicly provided health services (i.e. through general government expenditure on health services) (McIntyre et al., 2005). The National Treasury (i.e. Ministry of Finance) is being lobbied to change the existing tax

⁶ McIntyre *et al.* (2003) provide a detailed overview of these early proposals and how they envisaged achieving these stated objectives.

deduction into a direct government expenditure subsidy. It has been proposed that there should be an equal government subsidy per person. In the case of those not covered by medical schemes, this would take the form of government expenditure on publicly provided health services. For members of medical schemes, the subsidy would be paid into the REF and each member's contribution level would be reduced by that amount (McLeod, 2004). While the National Department of Health supports this approach, there is considerable resistance from National Treasury to its adoption. It is envisaged that income cross-subsidies will be further strengthened when the SHI is introduced if a proportional or progressive contribution schedule is adopted (at present it is estimated that the SHI contribution will be in the region of 4.5% of income).

The final step in the process of introducing a SHI is that of mandating health insurance cover for selected groups. At present, it is proposed that this focus on formal sector workers, and that it be initiated by mandating cover for civil servants in the first instance (as was done in Tanzania). The plans for a mandatory Government Employee's Medical Scheme (GEMS) is far advanced and is expected to be introduced in 2006. In preparation for the extension of mandatory health insurance to all formal sector employees, a government established task team is currently undertaking detailed research into the requirements for schemes to provide efficient cover of the prescribed minimum benefit package for low-income earners, given that it is low-income employees who are not currently covered by voluntary medical schemes, but would be required to obtain insurance cover under a mandatory system.

In summary, considerable research and planning has been undertaken in order to introduce a SHI in South Africa, and a number of crucial steps in the process towards this goal have been implemented while others are to be implemented in the next 2 years. Nevertheless, there remain conflicting views between the Department of Health and National Treasury on key issues which need to be resolved in SHI is to be implemented in a way that will promote risk- as well as income-related cross-subsidies. In addition, there remain concerns that a two tier health system could be entrenched by the planned SHI and that careful attention should be paid to how to promote cross-subsidies within the overall health system, rather than only within the insured group.

Ghana

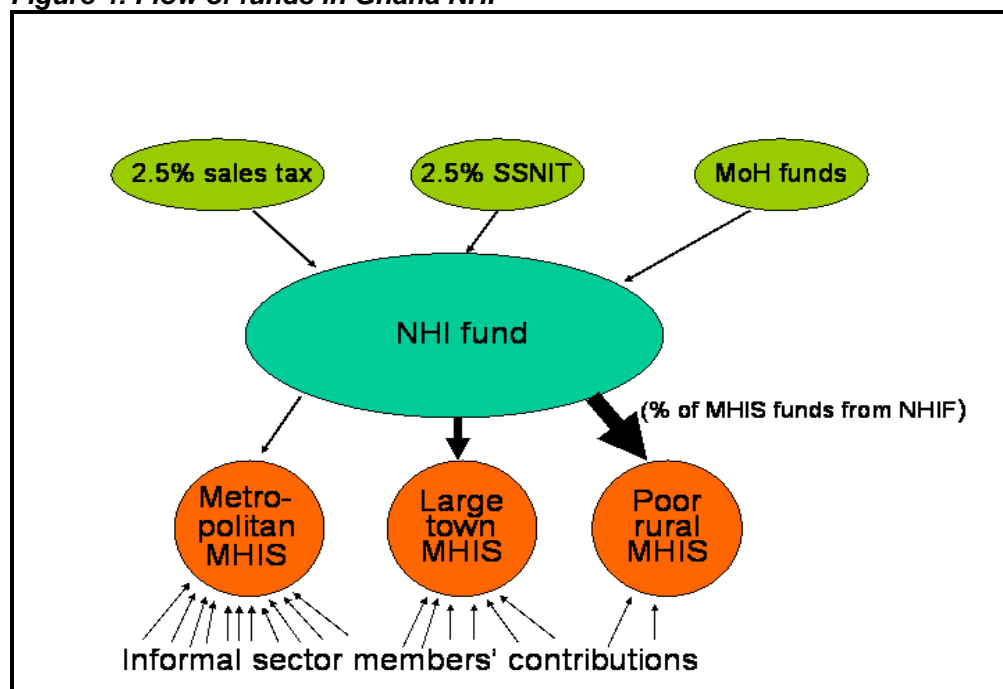
The Ghanaian government has made the boldest moves in relation to introducing mandatory health insurance seen in any African country to date. The stated motivation for introducing a NHI was to move away from the out-of-pocket payment system (called 'cash and carry' in Ghana) which was creating considerable equity concerns, largely due to non-functional exemption mechanisms (Nyonator and Kutzin, 1999), and towards a pre-payment system (Government of Ghana, 2003). The 'National Health Insurance Act' was passed in 2003 to operationalise this policy decision. The Ghanaian NHI will essentially combine SHI for formal sector employees with community-based health insurance schemes for the informal sector in order to create the NHI. The government is committed to universal coverage, but recognises that coverage will have to be gradually extended and the aim is to achieve enrolment levels of about 60% of residents in Ghana within 10 years of starting mandatory health insurance (Ministerial Task Team, 2002).

The basis of the NHI system will be district-wide 'Mutual Health Insurance Schemes' (MHIS) in each district in Ghana. The NHI Act explicitly requires every Ghanaian citizen to join either a MHIS or a private mutual or commercial insurance scheme (Government of Ghana, 2003). However, government subsidies will only be provided

to MHIS, thus creating a strong incentive for people not to 'opt out' of the integrated NHI system by purchasing coverage through private insurance organisations. Those employed in the formal sector will be covered through their payroll deducted contributions to the Social Security and National Insurance Trust (SSNIT) Fund (see below). Those outside the formal sector are expected to make direct contributions to their district MHIS, which are set at approximately \$8 per adult per annum for the poor, \$20 per annum for middle-income groups and \$53 per annum for high-income groups (National Health Insurance Secretariat, 2004). Each adult in a household is expected to become a MHIS member in their own right and pay the necessary contribution, which will cover themselves and dependent children under the age of 18. The National Health Insurance Fund (NHIF) will fully subsidise the contributions of the indigent.

The NHIF will be funded mainly by a NHI levy of 2.5% sales tax on almost all goods and services, a 2.5% payroll deduction for formal sector employees as part of their contribution to the SSNIT Fund and government allocations (including both general tax revenue and donor funding). The NHIF will allocate funds to each district MHIS in order to transfer the contributions of formal sector workers secured from the SSNIT payroll contributions, partially subsidise contributions for low-income households, fully subsidise contributions for the indigent and to serve a risk equalisation and reinsurance function. Figure 4 attempts to illustrate how the flow of funds within the NHI would function. It highlights that it is likely that a relatively high proportion of funds for MHIS in poor rural areas will be attributable to the NHIF given that they will have most of their members would require partially or fully subsidised membership.

Figure 4: Flow of funds in Ghana NHI



A relatively comprehensive benefit package is envisaged, including general and specialist consultations, a range of inpatient services as well as certain oral health, eye care and maternity services (Ministry of Health, 2004). Services that are excluded include appliances and prostheses, cosmetic surgery, anti-retroviral treatment, fertility treatment, dialysis for chronic renal failure, organ transplants,

medicines not on the essential drug list (EDL) and VIP wards. Services can be obtained from any accredited provider.

A National Health Insurance Council (NHIC) is also being established. It has wide-ranging responsibilities including: Registering and regulating all insurance schemes; accrediting providers and monitoring their performance; educating the public in relation to health insurance issues; resolving complaints arising from insurance schemes, members or providers; developing policy proposals on health insurance for submission to the Minister of Health; and managing the NHIF (Government of Ghana, 2003).

While many of the finer details of how the NHI will operate are still being resolved, Ghana is moving ahead with rapid implementation of this policy initiative. A number of important issues in relation to the Ghanaian NHI development should be noted. Firstly, the NHI is seen largely as an *alternative* financing mechanism, rather than a source of substantial additional resources. The government is anticipating devoting as much, if not more, tax revenue (and donor funds) to the health system. These funds will simply be channelled in a different way with funds gradually being redirected from the current Ministry of Health budget allocation channels to NHIF allocation channels. It is preferred to the current financing system because it will secure household contributions to health service funding (over and above tax payments) through pre-payment rather than out-of-pocket payment mechanisms. In addition, it is anticipated that exemption of the indigent will be more effective under the NHI than under the current user fee system. The main reason is that the indigent will be identified at community level in advance of needing to use a health service, in contrast to the current system of applying for an exemption at the health facility at the time of seeking care. This process will have the added benefit that health care providers will not be able to identify who is financially contributing to the district MHIS and who is not (is fully subsidised), as all can be issued with identical insurance membership cards, which will minimise any service discrimination against the poor.

Secondly, the NHI builds on the well-established tradition of community pre-payment schemes in Ghana. There are several hundred of these schemes in Ghana, which has ensured that many Ghanaians are familiar with health insurance principles and the operation of MHIS. However, the fate of existing community-based schemes was a major concern when the NHI was first announced. The Act clarifies that existing community-based schemes may continue to operate independently, but will not receive a subsidy from the NHIF. Attention has now turned to identifying ways of incorporating existing community-based schemes into the new district-wide MHIS (e.g. to serve as the sub-district office of the district MHIS).

Finally, there is considerable government and donor support to promote successful implementation of the NHI. The NHI was announced as an election promise and it is a promise that the government is committed to fulfilling. While many donors were initially concerned about the feasibility of such a major and ambitious health care financing restructuring initiative, they have now also committed themselves to providing all possible support for its implementation.

Kenya

Kenya is one of the few African countries that already has some mandatory health insurance, which takes the form of the National Hospital Insurance Fund (developed in the late 1960s) which covers formal sector employees and their dependents (currently approximately 7 million people). This fund only covers limited fees for inpatient hospital services (not at a cost-recovery level) and currently contributes only 3.9% of resources for health care expenditure in Kenya (Ministry of Health, 2004).

The Ministry of Health in Kenya released proposals to establish a full NHI in May 2004 for a NHI that was intended to be implemented on 1 July 2004 (Ministry of Health, 2004). However, the proposals had not yet been implemented at the date of writing.

The stated objective was similar to that in Ghana, namely to move away from out-of-pocket to pre-payment for health services. The policy statement on the NHI indicated that it would “ensure that every Kenyan pays small regular contributions to the National Social Health Insurance Fund before an illness occurs. When illness occurs, Kenyans will not pay medical care at the time and point of treatment” (Ministry of Health, 2004).

The proposed benefit package was not spelt out in detail, but was intended to include both outpatient and inpatient services at accredited facilities. Funding would take the form of payroll contributions for those in the formal sector, contributions via community-based intermediaries (e.g. co-operatives, artisans associations, NGOs, churches etc.) to the National Social Health Insurance Fund for those outside the formal sector and government contributions on behalf of those unable to pay.

Although limited details are available on the intended NHI in Kenya, the information that is available indicates that there are many similarities to the overall objectives and design of the Ghanaian NHI.

Overall issues

The above country case-studies highlight that there has been considerable interest in pursuing mandatory health insurance options in a number of African countries in recent years (late 1990s and early 2000s). However, there are different objectives and different approaches to the design of these schemes across countries.

On the one hand, some countries (e.g. Ghana and Kenya) are explicitly pursuing the introduction of mandatory insurance as a mechanism for moving away from user fees. In both countries, policy documents announcing the proposed NHIs specifically mention that there is a concern about the adverse equity consequences of user fees and that they intend introducing pre-payment mechanisms to ensure that the population has access to health care when needed without the burden of paying out-of-pocket at this time. The insurance schemes will not only reduce the need to pay user fees, but could also reduce other out-of-pocket payments which are made to private providers. This is so as the insured can use a range of providers if they have been accredited (on the basis of providing adequate quality of care and willingness to accept insurance scheme reimbursement rates). Accreditation will include both public and private not-for-profit (e.g. mission facilities) facilities, given that in many countries mission facilities are the only providers in certain locations and in these instances are the designated district facility. Private for-profit facilities could also be accredited if they are willing to charge the insurance company reasonable rates. Thus, the only out-of-pocket payments would relate to services outside of the benefit package, if any co-payments are introduced or if the accredited facility does not have the necessary drugs in stock. As essential drug stock-outs is a pervasive problem in many public sector facilities in Africa, careful attention to improving drug procurement, distribution and stock control should be a major focus during insurance scheme implementation in order to ensure that out-of-pocket payments are reduced in reality.

On the other hand, other countries (e.g. South Africa) are pursuing mandatory insurance as a means to addressing problems encountered with private voluntary insurance. In South Africa (and in Tanzania), the intention is also to extend

insurance to a larger section of the population, so that people who are able to pay for health services but not necessarily at the time of using a service, can contribute via a pre-payment mechanism and hence reduce the burden on the public sector.

There are also differences in terms of preferring a SHI or a NHI from the outset. A point worth noting is that both countries that cited reducing the burden of out-of-pocket payments as the major motivation for introducing mandatory insurance decided to implement a universal or national health insurance system. In countries which have opted for a SHI, those who are not (or will not be) covered under this mandatory insurance either have to pay out-of-pocket when they use a health services (as in South Africa) or have a choice between joining a community pre-payment scheme or paying out-of-pocket (as in Tanzania). This highlights that the choice between a NHI and a SHI is very closely linked to the policy objective for mandatory insurance (i.e. whether the emphasis is on to move away from out-of-pocket payments or simply extending insurance coverage).

For countries that have chosen to go the SHI route, there are two important concerns. Firstly, it entrenches a two tier health system. While most countries intend to ultimately move towards a NHI with SHI being the first step, a deep divide between the insured, who have excellent access to a wide range of high quality health services, and the uninsured who often are consigned to under-resourced and poor quality public sector services for the poor, will remain for many decades. The second concern is that in many instances, the first group to be covered by mandatory health insurance are civil servants. In many ways this is a sensible approach as civil servants are often the single largest group of formal sector employees in African countries. However, it must be recognised that limited government funds will be used to purchase mandatory insurance cover for this group. Thus, while the stated goal may be to reduce the burden on public services, the cost of insuring civil servants may exceed the resources 'released' by this group through reduced use of public sector services without cost-recovery payments (Kutzin, 1998). In this way, there may in fact be fewer government resources available for providing services for those who are dependent on publicly-funded services, hence the observation that the uninsured will only have access to under-resourced, poor quality public sector services.

For countries that have opted for NHI from an early stage, there are certain benefits but also considerable challenges. The major benefit from an equity perspective is that there is the political intention to achieve universal coverage in an integrated health system from the outset in the shortest possible period. Explicit mechanisms to include those within the formal sector and those outside it are introduced from the outset. Another benefit is that it is easier from an implementation perspective to introduce mandatory insurance with a common benefit package and contribution schedule from the outset rather than allowing the fragmented development of voluntary insurance schemes with a wide range of benefit packages and contribution schedules and trying to integrate them at a later stage. Indeed, this is one of the challenges facing Ghana as there is resistance from existing community-based pre-payment schemes as they need to restructure their contributions and benefit packages in order to participate in the mandatory scheme. A key challenge with embarking on a NHI from the outset of introducing mandatory insurance is that of sustainability. Considerable administrative, financial management and actuarial capacity is needed in order for the NHI to succeed. In addition, in the context of a small formal sector, with those outside the formal sector only able to make limited financial contributions, and high poverty levels, there are serious concerns about the financial viability and sustainability of the NHI scheme. Clearly substantial government (and donor) funding is needed, but there is uncertainty about whether

these resources will be adequate to cope with the increased utilisation of health services that will inevitably arise when financial barriers to accessing services are removed.

Given that these mandatory health insurance initiatives have only been introduced very recently, there are many questions about the advantages and disadvantages of different approaches within the African context that will remain unanswered for some time to come. The issue of mandatory health insurance is one that requires extensive additional research and careful planning, monitoring and evaluation of its implementation in countries which have recently, or are about to, introduce this form of insurance.

4.5 Overall health care financing issues

As is evident from the above review, no country has a single source of financing for health care services. Instead, a combination of alternative financing mechanisms is drawn on to fund the overall health system. Even if the main financing mechanism is a universal mandatory health insurance scheme, there are a number of different sources of funding for this scheme (e.g. payroll deductions for formal sector workers, direct pre-payment contributions by the non-poor population outside the formal sector, general tax revenue and donor funding). Each financing mechanism could potentially have negative effects on equity or may enhance equity, depending on how it is structured and the context within it is operating. A key challenge facing governments in Africa (and indeed worldwide) is how to adapt this combination or package to strengthen existing financing mechanisms.

A starting point in this regard could be to undertake research to identify who bears the burden of contributing to (financing incidence) and who benefits from (benefit incidence) each financing mechanism and to what extent, and to assess the overall incidence (financing and benefit) within a country. This will enable policy-makers to identify how each mechanism is contributing, or creating obstacles, to equitable health system financing. A detailed illustration of how one would assess financing and benefit incidence and the overall equity of a health system with a range of health care financing mechanisms is provided in Appendix A (this information has been placed in an appendix so as not to interrupt the overall flow of argument, not because it isn't important and interesting; it's worth reading!).

Once there is a good understanding of the financing and benefit incidence of each financing mechanism, it is possible to assess what needs to be done to address any existing inequities or to further enhance equity. Table 4 provides an overview of some of the key issues that need to be addressed in order to promote equity in the distribution of the burden of paying for health care and of the benefits from services for each financing mechanism.

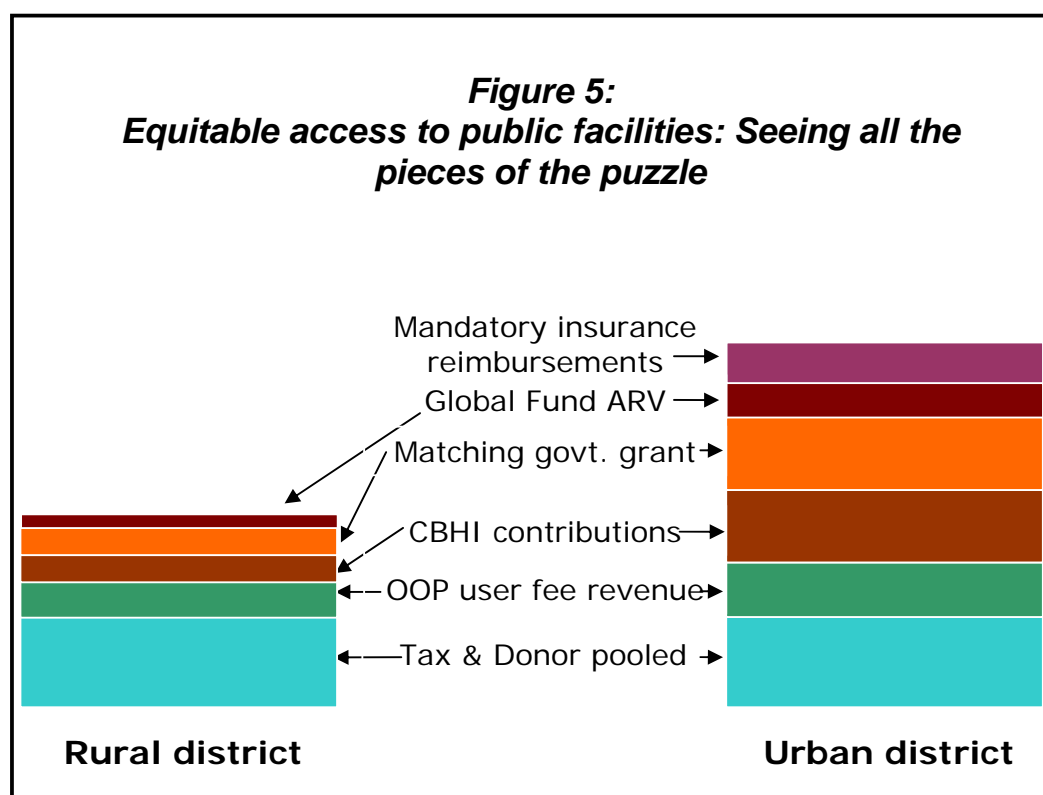
Table 4: Equity promotion strategies according to financing mechanism

Financing mechanism	Promoting equitable distribution of financing burden	Promoting equitable distribution of service benefits
General tax revenue	<ul style="list-style-type: none"> Progressively structured personal income tax Reasonably substantial company income tax component Low proportion of general tax revenue contributed by VAT Good tax compliance and efficient revenue collection 	<ul style="list-style-type: none"> Allocate government funds for health services according to relative need of the population Higher income groups using public sector services should contribute to cost (preferably through insurance) Ensuring 'paying' patients do not 'crowd out' the poor
Donor funding	<ul style="list-style-type: none"> Mainly in the form of grants rather than loans Avoid macroeconomic policy conditions that could exacerbate poverty or inequitable income distribution 	<ul style="list-style-type: none"> Use of donor funds in line with national health policy priorities (preferably through domestic government-led decision-making process)
Mandatory health insurance	<ul style="list-style-type: none"> Progressive, or as a minimum proportional, contribution structure; avoid flat rate contributions Partially subsidised contributions for low-income and fully subsidised contributions for poor in universal NHI Ensure employer contributions for civil servants does not exceed government resources 'released' through reduced use of heavily subsidised public sector services Use risk-equalisation mechanism if a number of schemes involved (ensure higher risk, usually vulnerable, groups don't pay more) 	<ul style="list-style-type: none"> Improve geographic distribution of services to ensure equitable access to benefit package (real access not just entitlement) Avoid or minimise co-payments (influence use by members through other means, e.g. PHC gatekeepers) Risk-equalisation to ensure each scheme has adequate resources to meet needs of members, given its risk profile
Private voluntary employment-based insurance	<ul style="list-style-type: none"> Income-related rather than flat rate contributions Avoid high levels of tax subsidies to private insurance members 	<ul style="list-style-type: none"> Avoid or minimise co-payments
Community-based health insurance	<ul style="list-style-type: none"> Income-related sliding scale for contributions; not single rate Adjust contributions for family size Subsidise contributions for low income if feasible 	<ul style="list-style-type: none"> Avoid or minimise co-payments Design package to meet needs of community served
Out-of-pocket payments	<ul style="list-style-type: none"> Minimise reliance on this source of funding Exempt the poor and other vulnerable groups Encourage private providers to introduce price discrimination in their practices (higher fees for the rich to subsidise lower fees for the poor) 	<ul style="list-style-type: none"> Exempt the poor and other vulnerable groups

It is not only important to consider the equity of each financing mechanism, but also overall health system equity when all financing mechanisms are considered together. In many African countries, these financing mechanisms are extremely fragmented and there are limited cross-subsidies in the overall health system. For example, if a country has voluntary health insurance whether in the form of private employment-based insurance or community-based health insurance, there are usually a large number of these schemes that operate completely independently of each other. If there is also a heavy reliance on out-of-pocket payments, cross-subsidies between

the rich and the poor and from the healthy to the ill will virtually be non-existent. There will probably only be a small element of risk (healthy to ill) cross-subsidy within each voluntary insurance scheme, but none between individual schemes nor between individuals paying out-of-pocket, and there will be no income (wealthy to poor) cross-subsidy, unless there was a progressively structured insurance contribution scale. This fragmentation and lack of cross-subsidies adversely impacts not only on health system equity but also on efficiency and sustainability. For example, if there are a large number of small insurance schemes, each will have a very small risk pool, as a result of which they frequently experience sustainability problems. Thus, a key challenge is to find mechanisms for reducing fragmentation and facilitating linkages and cross-subsidies between the different financing mechanisms.

The existence of a range of alternative financing mechanisms also has implications for the equitable allocation of government resources (and donor funds if these are pooled with tax funding through SWAs or general budget support). This is highlighted in Figure 5 which compares the possible situation in a rural and urban area.



The bars represent the level of funding from alternative sources on a per capita basis. The bottom block in each bar indicates that government has allocated its resources on an equal per capita basis. The next bar indicates that more user fee revenue is generated in the urban district than in the rural one, due to greater ability to pay amongst urban dwellers working in the formal or informal sectors. The same applies to community-based health insurance (CBHI) contributions. Assuming government matches CBHI contributions on a 'dollar for dollar' basis, this again preferentially benefits the urban district. The block that is second from the top of the right-hand bar (and top of the left-hand bar) represents donor *program funds* that are at present likely to be heavily concentrated in urban areas. For example, Global

Fund resources for the provision of ARVs are likely to flow largely to urban areas, at least in the initial stages of the ARV roll-out, given that it will be far easier to provide these services to urban residents. Finally, the top block of the right-hand bar represents revenue that public sector facilities, particularly hospitals, may generate in the form of mandatory health insurance reimbursements when their members use these facilities. Given that mandatory insurance members will be heavily concentrated in urban areas, such funds may not even accrue to rural facilities.

This illustrates how significant inequities in the allocation of health care resources may arise, even when government allocates its tax resources on an equal per capita basis. It raises the importance of taking a comprehensive view to the health system and to consider the equity of each financing mechanism and the impact of each mechanism on equitable financing in the overall health system. Further, government allocations are a critical way of offsetting disparities arising from other health care financing mechanisms and these disparities should explicitly be taken into account when allocating government (and pooled donor funds) across geographical areas.

A final issue that requires consideration is that of mechanisms (e.g. exemptions) for protecting the poor and other vulnerable groups. Such mechanisms would not be required if the health system was *entirely* funded by tax (and pooled donor grant) funding, i.e. if no one had to contribute to a health insurance scheme or make any out-of-pocket payments. It is already well recognised that exemptions are required within a user fee system. There has been a more recent recognition that there may be a need to accurately identify the poor in order to subsidise health insurance membership for them, where the emphasis is placed on pre-payment rather than out-of-pocket payment financing mechanisms. However, there has been very little detailed consideration of whether including the poor in health insurance schemes is the most appropriate way of ensuring their access to health services. On the one hand, given the relative lack of experience of health insurance within the African context, it is questionable whether the service access fate of the most vulnerable groups in society should be placed in the hands of largely unproven institutions. On the other hand, if insurance becomes a dominant health care financing mechanism, not including the poor may simply create a two tier system. Another mechanism that has recently been used to ensure that the lowest-income groups benefit from tax funds is to issue them with vouchers which they can present at health facilities in return for specified services (Ensor, 2004). Facilities then present these vouchers to the local health department who reimburses the cost out of general tax funded budgets. Whatever is finally decided in specific countries, it will be necessary to identify the poor in order that adequate resources can be directed (whether through traditional government budget channels or into special funds to cover voucher reimbursements, or fee or insurance contribution exemptions) to secure health care access for the poor.

It is not necessary to provide detailed information on alternative ways to design exemption mechanisms as others have provided extensive reviews of these issues (Bitrán and Giedion, 2003, Newbrander et al., 2000). However, it is necessary to highlight the fact that exemption mechanisms which target specific demographic groups (e.g. the elderly, children under a specified age and pregnant women) and health services regarded as a priority (e.g. ante-natal care, immunisations) are most frequently used, not least of all because of the greater ease in identifying the intended beneficiaries. Without exception, health service providers in countries around the world find it most difficult to accurately identify and protect the poor. Means testing is time-consuming, resource intensive and frequently inaccurate if undertaken at the time of use of health services.

There is clearly an urgent need to develop effective mechanisms for identifying and protecting the poor. While there is no 'ideal' system to use as a model, the key elements of such a mechanism would include:

- Identification of the poor should occur in advance of the need to use a health service (i.e. should not be left to health service providers to undertake when a patient presents at a facility). There are a number of reasons for this including: difficulty in accurately determining a person's socio-economic status as the provider has no knowledge or evidence of their status; and a poor person may not incur transport costs (financial or time lost to work) to seek care if they are not certain that they will be exempted.
- Instead, identification of the poor should be done at community level at a specified time and the person/household issued with some form of card or certificate. The key problem with this approach is that it could stigmatise those with these cards or certificates and they may be discriminated against in the quality of care they receive. In the case of identification for purposes of granting subsidised health insurance membership, this can be avoided as the poor can be issued with identical cards to those who are contributing financially to the insurance scheme.
- Verifiable proxy indicators of poverty or vulnerability, that are appropriate to the specific community, should be identified. These may take the form of asset ownership (e.g. livestock), housing conditions, access to essential services (e.g. potable water and sanitation), etc. Clearly these indicators would be different in rural and urban areas.
- Careful attention should be paid to who should undertake the identification process. It may be appropriate for a staff member of a social welfare or poverty alleviation office to assume this responsibility (in fact, the health sector may be able to 'piggy-back' onto existing identification procedures undertaken for other social sectors). It is also important to get community level input to the process, as it is community members who are most familiar with the socio-economic circumstances of neighbouring households. However, previous experience has shown that the process can be open to abuse if left entirely to an individual community leader.
- The process of implementation should be monitored and evaluated to identify problems and address them.

5. Implications for policy, advocacy and research

The review above highlights that:

- Out-of-pocket payments are the single largest source of health care finance in many African countries and impose a very heavy burden on households, particularly the poorest;
- There is still a relatively heavy reliance on donor funding, but this source of finance can be unreliable;
- General tax funding is a critical component of the health care financing in all African health systems, but the ability to dramatically increase allocations from this source to the health sector in the short-term remain constrained, particularly given the equally urgent need for additional tax funding for other social sectors (noting that many of the activities in these sectors indirectly contribute to improved health status);
- Health insurance, both voluntary and mandatory, is quite limited at present but there is considerable and rapidly growing interest in expanding this financing mechanism.

Enormous constraints and challenges face African countries in relation to health care financing. From the perspective of pursuing financing strategies that will promote equity and alleviate poverty, rather than contribute to further impoverishment of vulnerable households, the following principles to guide consideration of alternative financing mechanisms within individual country contexts are suggested:

- The mechanism(s) should provide financial protection, i.e. should ensure that no one who needs health services is denied access due to inability to pay and households' livelihoods should not be threatened due to the costs of accessing health care. This implies that health care financing contributions or payments should be separated from service utilisation, which requires some form of pre-payment.
- Health care financing contributions should be distributed according to ability-to-pay. In particular, progressive health care financing mechanisms (i.e. where those with greater ability-to-pay contribute a higher *proportion* of their income than those with lower incomes) should be prioritised (see further discussion below).
- Cross-subsidies (from the healthy to the ill and from the wealthy to the poor) in the overall health system should be promoted. This implies that fragmentation between and within individual financing mechanisms should be reduced and that mechanisms should be put in place to allow cross-subsidies across all financing mechanisms.
- Mechanisms to ensure that financial resources are translated into universal access to health services should be put in place. This implies that all individuals should be entitled to benefit from health services via one of the funding mechanisms in place, the package of benefits to which they are entitled is explicit (so that individuals are aware of their entitlements to enhance their claims on these entitlements), there is active purchasing of services whereby 'value for money' is secured (both in terms of efficiency and quality), and there is adequate physical access to services to which one is entitled.

Many of these principles are in line with those proposed by WHO in relation to what constitutes 'fair financing' within health systems (World Health Organisation, 2000). The main area in which we differ from the WHO's interpretation of fair financing is that we propose that progressive financing as opposed to proportional financing mechanisms should be pursued. The WHO clearly stated that it favoured proportional systems, where every individual contributes the same proportion of her/his income towards health care. As has been noted by others, this preference for proportional funding implicitly views regressive funding (where the poorest contribute a higher proportion of their income than the rich) and progressive funding as equally unfair (Wagstaff, 2000). The international health care financing literature and national health policy statements overwhelmingly support the notion of progressive funding as being the fairest approach. In the African context, with high existing poverty levels and a continual process of further impoverishment due to illness-related costs, we have no hesitation in supporting a preference for progressive health care financing mechanisms.

From a practical perspective, the above principles suggest the following actions in relation to health care financing within the African context:

- Explicit commitments by African governments to move away from out-of-pocket funding mechanisms for public sector health services, and actively pursuing alternative financing mechanisms to make this a reality.
- Urgent efforts to increase the health sector's share of government resources in line with the existing commitment of African Heads of States in Abuja to a 15% share for health. This should not be done at the expense of other social services, recognising that these services also contribute to improving the health status of the population. These decisions should occur within the context of more open,

public debate about the relative priorities for the use of limited government resources.

- In order for this to be achieved, there should be unconditional cancellation of African governments' external debt, to allow governments to devote limited tax revenue to health care to achieve the Abuja goal, rather than to debt servicing and repayment. There should also be other efforts to increase domestic tax resources that do not necessarily require increases in personal income tax rates, such as improved tax collection procedures and levying appropriate corporate and wealth taxes (particularly on international corporations currently extracting considerable profits from their activities in African countries).
- As general tax funding and health insurance options are most closely aligned with the above principles, introducing or expanding insurance mechanisms should be given serious consideration to supplement limited tax resources. There is an urgent need for additional research into appropriate health insurance within the African context, and much can be learnt from monitoring and evaluating the experience of countries which are already moving ahead with implementing mandatory insurance. There should also be more sharing of experiences with insurance across the region and increased policy dialogue about these options. There may also be value in other countries piloting and gradually introducing health insurance schemes, but only once a careful feasibility assessment has been undertaken.
- Active management of donor funding, to ensure that national Ministries of Health lead and control decisions on the use of these funds to ensure that they contribute to achieving national health priorities.
- Equitable allocation of funds that are mobilised through the above strategies, to ensure that all citizens of African countries have access to health services irrespective of whether they reside in a rural or urban area.

The available experience also stresses the importance of carefully planning the implementation of any of new financing policy developments. The experience of removing user fees discussed earlier clearly demonstrates the importance of planning implementation processes (Gilson and McIntyre, 2005). Broader experience of financing policy implementation suggests that the range of strategies that can support implementation include ensuring that the views of beneficiaries are taken into consideration when designing new policies, gaining support from the health staff responsible for implementation, and ensuring monitoring and evaluation systems that do not simply measure progress towards targets, but rather represent 'early learning' mechanisms that allow the process, as much as the design, of interventions to be adapted as implementation proceeds (Gilson et al., 1999, Goudge et al., 2003).

Finally, the review presented here highlights a number of areas that should receive priority in future research:

- It is important to gain a better understanding of who contributes to and benefits from each financing mechanism and to what extent, and how this impacts on overall health system equity (i.e. to assess the distribution of financing burdens and service benefits across the whole package of health care financing mechanisms in a country). While there is growing evidence in this regard for high-income countries and in some middle-income countries, there is extremely limited empirical evidence within the African context. For example, it is not known whether indirect taxes or voluntary health insurance contributions are currently progressive or regressive in different countries on the continent. More importantly, evidence on the equity impact of the mix of health care financing mechanisms in African countries is virtually non-existent.
- International evidence overwhelmingly indicates that health care systems that are predominantly tax funded are the most equitable. Further research is needed in

the African context to identify ways of increasing and sustaining tax revenue allocations for health services. Research is also required to assess whether it is feasible to achieve universal health systems that are largely tax funded in the African context, given that the percentage contribution of tax revenue to total health care expenditure is currently very low. Research should, thus, also consider other feasible mechanisms (e.g. combinations of general tax and mandatory insurance funding) for moving towards universal and equitable health systems.

- Critical evaluation of the full range of health insurance options in the African context is possibly the greatest priority for future health care financing research if we are to ensure that health insurance developments promote rather than undermine health system equity in Africa. It is necessary to create a solid evidence base, for example to identify effective strategies for achieving high coverage levels, equitable yet easily administered contribution scales, sustainable benefit packages, addressing moral hazard, etc.
- There is an urgent need to investigate effective mechanisms for identifying the poor and other vulnerable groups. Mechanisms for exempting the poor from user fees have been difficult to implement and relatively unsuccessful in most cases. Even if there is movement away from this form of financing in favour of health insurance mechanisms to supplement tax funding, it will be necessary to protect poor and other vulnerable households by either fully or partially subsidising membership of these schemes or ensuring appropriate access to tax funded health services if we are to progress to universal and equitable health systems. It is thus essential to explore the most effective mechanisms for identifying and providing financial protection for the poor, including critically evaluating mechanisms for targeting individuals compared with other targeting mechanisms (e.g. geographic targeting).
- Better understanding of how to manage processes of policy development and implementation to support the achievement of objectives, and to guard against possible opposition and resistance to new policies.

In addition to the abovementioned research, there needs to be more dissemination of evidence, exchange of information on promising practice and policy dialogue to provide and use a good evidence base to promote the design and implementation of equitable health care financing systems. EQUINET plans to initiate a program of research, information dissemination, policy dialogue and support of policy processes to contribute to the development and uptake of this evidence base.

APPENDIX A: DETAILED ILLUSTRATION OF FINANCING AND BENEFIT INCIDENCE INTERACTIONS

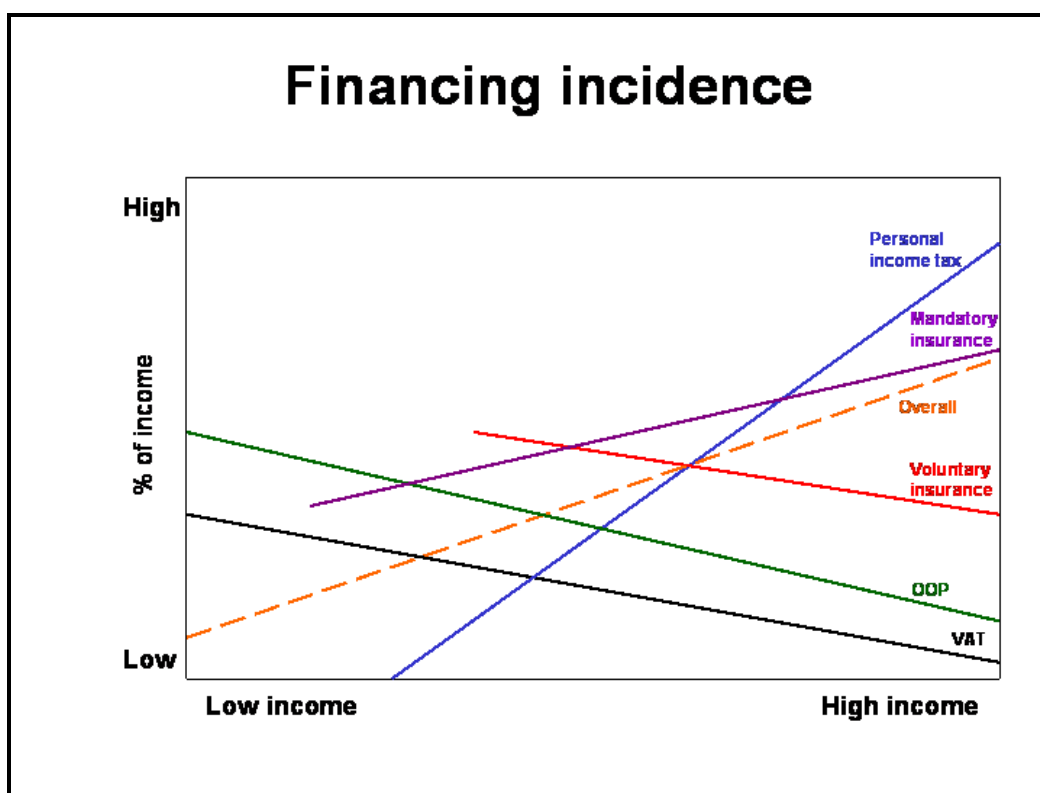
The series of three figures below attempts to illustrate what the financing, benefit and overall incidence may be in a particular country. It should be noted that these are merely illustrative; the graphs are unlikely to be straight lines and more likely to be curved in reality, and the line for a particular financing mechanism may be upward sloping in some contexts but downward sloping in others.

The first figure illustrates financing incidence by comparing the percentage of total income that is contributed to a particular health care financing mechanism across income groups (note that the vertical axis does not extend from 0% to 100%, but merely represents relatively low and high levels of contributions as a percentage of household income). In this example, the following issues are highlighted:

- Personal income tax is progressively structured, i.e. higher income groups contribute a higher percentage of their income towards this tax than lower income groups (and the line is upward sloping). There are some very low income groups that do not pay any income tax.
- Value Added Tax (VAT) is represented as being regressive, as lower income groups pay a higher percentage of their income towards VAT in this example (the line is downward sloping). As was mentioned previously, VAT may be progressive in some countries with a substantial informal sector (particularly in relation to the sale of fresh foodstuffs). It should be noted that every person contributes something to VAT.
- Out-of-pocket (OOP) payments are also represented as being regressive in this example (there are very few instances where OOP payments are not regressive). Again, it is assumed that everyone makes some OOP payments for health services; for the lowest income groups, this is likely to take the form of user fees at public sector facilities or purchasing occasional medicines from an informal drug seller or a traditional healer and for high income groups this may take the form of co-payments required by their insurance scheme or payments for services not covered by the insurance benefit package.
- Voluntary insurance contributions are represented as being regressive. This will occur when a flat rate or a risk-rated contribution is charged (given that lower income groups tend to have a greater risk of ill-health). Again, only part of the population contributes to such schemes, with middle- and high-income groups being the most likely to purchase voluntary insurance (particularly in the case of private voluntary insurance, but the lowest income groups are also likely not to be covered even in community pre-payment schemes).
- Mandatory insurance is represented here as being progressive, which would occur if contribution rates increase with income. Frequently these contributions would be proportional (i.e. each person contributes the same percentage of their income to the mandatory insurance) which would result in a flat horizontal line, but may be regressive if there is a flat rate contribution (i.e. each person pays the same monetary amount, which translates into a higher percentage of income for lower income groups than higher income groups). In this example, it is assumed that not everyone contributes to the mandatory insurance. This would occur either when there is a SHI or where everyone is a member but the lowest income groups do not have to contribute themselves. In either case, the number of people contributing to this form of insurance is greater than in the case of voluntary insurance.
- This example indicates that the health care financing mechanisms are progressive overall. The incidence of all financing mechanisms combined is dependent on the percentage share of each mechanism to total health care

financing and the extent to which each mechanism is itself progressive or regressive. In this example, the progressive overall financing incidence implies that a relatively high proportion of health care resources are attributable to mandatory insurance and general tax revenue, and that personal income tax is the major source of general tax revenue. The overall financing incidence would be regressive (and the line would be downward sloping) if OOP payments were a major source of health care financing (as is the case in many African countries) and if VAT contributes a substantial amount of general tax revenue.

Donor funding is not included in the figure below. In the case of donor grants, the incidence falls on residents of the donor countries; although these funds will potentially ease the burden of health care financing on individual households within the recipient country, this impact cannot be directly measured. In the case of donor loans, the loans and interest repayments will have to be repaid from tax funds over an extended period and will thus have a similar financing incidence to the existing tax structure.

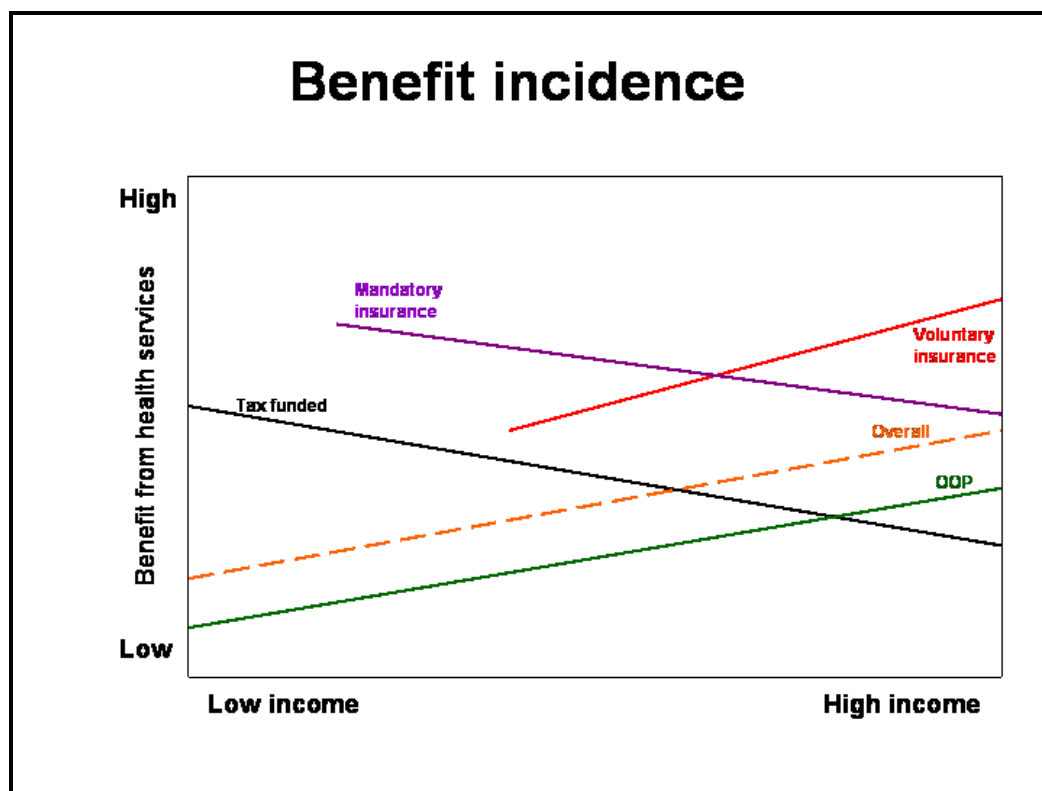


The next figure illustrates benefit incidence by comparing who benefits from health services across income groups. The vertical axis in this figure is different to that in the financing incidence figure; here it tries to reflect the extent to which an individual actually benefits from (or accesses and uses) a health service. In benefit incidence studies, this is expressed in monetary terms as the total cost of the services used. If one bears in mind that the lowest income groups tend to have the greatest need for health services, a downward sloping curve would be equitable as those with the greatest need (lowest income) are deriving a greater benefit. In this example, the following issues are highlighted:

- Tax funded health services are used more by lower income groups than high income groups and in this case the poor benefit most from these services. As indicated previously, there are a number of examples of African countries where

this does not occur, for example where the poor are only able to access very limited public services at the primary care level while high- and middle-income groups access expensive urban-based public hospitals and do not pay (or pay very little) for such care.

- In this example, the rich benefit more from OOP payments. The major reason for this is that the lowest income groups are only able to use services funded by this means very infrequently and hence derive relatively less benefit than higher income groups. This may seem contradictory when one compares the financing and benefit incidence curves for OOP payments because in the case of OOP payments, you 'get what you pay for'. However, while the poor pay a higher *percentage* of their incomes in OOP payments than the rich, the actual monetary amount of these payments is lower for the poor than for the rich. For example, a \$1 payment by a person with a monthly income of \$10 is 10% of their income, while a \$5 payment by a person with a monthly income of \$500 is 1% of their income.
- In the case of voluntary insurance, the rich are represented here as deriving greater benefit. This will occur when lower-middle income groups belong to insurance schemes that offer a very limited benefit package while higher income groups are able to purchase the most comprehensive packages. Also, if co-payments are required, higher income groups are more able to make these payments and hence use services subject to a co-payment than lower income groups. This pattern may not occur if the voluntary insurance system has a good mechanism for ensuring risk (healthy to ill) cross-subsidies within the insured population. It should be noted that only those who contributed to voluntary insurance derive any benefits from this source of funding.



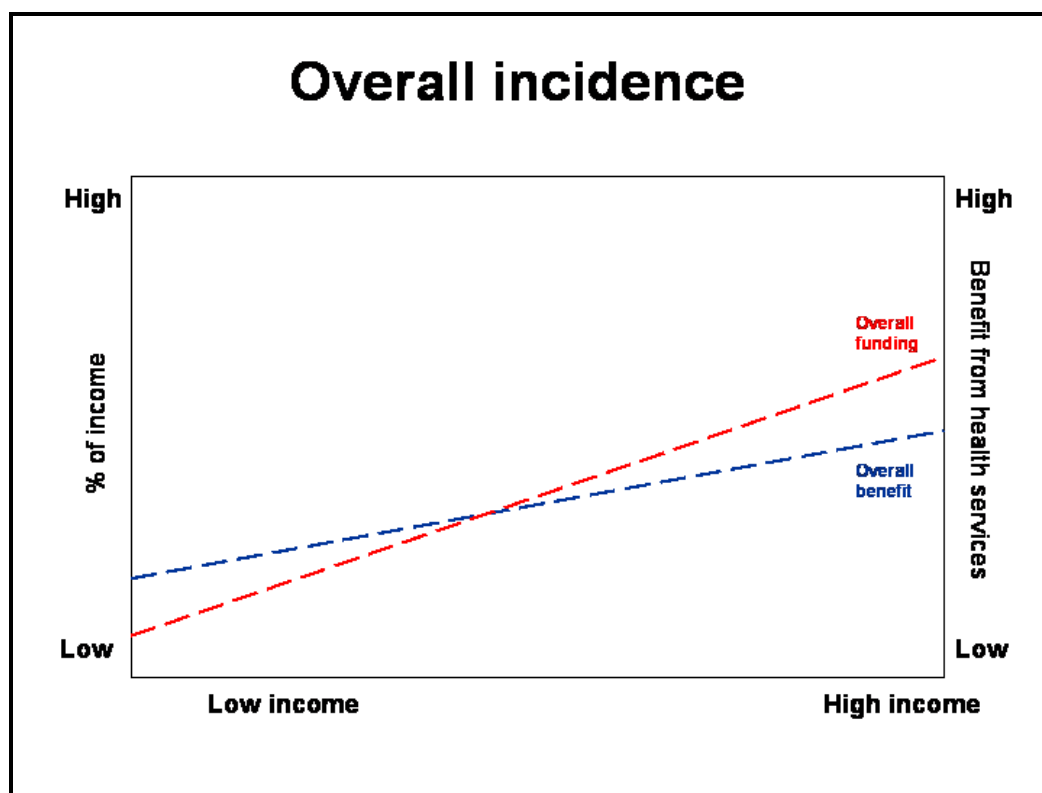
- Services available under mandatory insurance are represented here as benefiting lower income groups more than higher income groups. This is likely to occur with the increased likelihood of appropriate risk (healthy to ill) cross-subsidies existing

in a mandatory than a voluntary health insurance environment. Once again, only those who contribute to this insurance system benefit from it (i.e. in this case, it represents a SHI).

- In this example, overall benefits from health services, when combined for all financing mechanisms, are greater for higher than lower income groups. As with financing incidence, the overall benefit incidence is dependent on the percentage share of benefits secured through each financing mechanism and the extent to which each financing mechanism provides access to service benefits when needed.

Once again, donor funding is not included in the benefit incidence figure. Donor funding, if directed to services which are needed by the local population and which can be easily accessed, could have a positive impact on benefit incidence. Equally, it could have a negative impact if these funds are directed to services which are perceived as priorities by donors but which do not meet the needs of the local population.

The final figure combines the overall financing and benefit incidence curves. At first glance, it appears that the health system described in this example is equitable: The overall burden of health care financing is progressive; the rich are contributing a greater share of their income than the poor. In addition, lower-income groups are obtaining greater benefit from the health system than they are contributing in financial terms. However, it should be borne in mind that lower income groups tend to bear a greater burden of ill-health and thus have a greater need for health services than the rich. From an equity perspective, benefit should be distributed according to need rather than according to ability to pay or according to the actual financial amount contributed. Thus, in an equitable health system, we would expect a downward sloping overall benefit curve.



APPENDIX B: KEY HEALTH EXPENDITURE AND MACROECONOMIC DATA FOR SUB-SAHARAN AFRICAN COUNTRIES

Country	Total expenditure on health as % of Gross domestic product	Government expenditure on health as % of total government expenditure	Government expenditure on health as % of total expenditure on health	Private expenditure on health as % of total expenditure on health	External resources for health as % of total expenditure on health	Social security expenditure on health as % of government expenditure on health	Private Prepaid plans as % of private expenditure on health	Out-of-Pocket expenditure as % of private expenditure on health	GDP per Capita,2000, current prices,USD
Angola	5	4.1	41.9	58.1	7.9	0	0	100	665
Benin	4.7	11.1	44.4	55.6	65.9	n/a	9	90.3	360
Botswana	6	7.5	61.9	38.1	3.8	n/a	19.9	30.8	3,690
Burkina Faso	4.3	10.6	45.9	54.1	5.8	0.9	n/a	98.9	191
Burundi	3	2	21.5	78.5	16.2	n/a	n/a	100	117
Cameroon	4.6	7.9	26.2	73.8	6.4	0.1	n/a	93.7	578
Cape Verde	5	11.1	75.1	24.9	19.3	33.6	0.2	99.8	1,408
Central African Republic	3.9	7.4	41.6	58.4	17	n/a	n/a	95.4	249
Chad	6.5	12.2	41.9	58.1	27.9	n/a	0.4	96.5	186
Congo	2.2	6	70.3	29.7	2.2	0	n/a	100	963
Côte d'Ivoire	6.2	7.2	22.4	77.6	2.2	23.5	5.4	94.6	575
Democratic Republic of Congo	4.1	16.4	30.2	69.8	27.8	0	n/a	100	103
Djibouti	6.3	10.1	52.9	47.1	20.3	0	n/a	52.9	825
Equatorial Guinea	1.8	9.8	72.2	27.8	4.8	0	0	80.5	2,652
Eritrea	5.1	5.6	63.7	36.3	49.2	0	0	100	171
Ethiopia	5.7	7.6	44.9	55.1	29.5	0.5	0.4	65.9	99
Gabon	4.3	6.3	41.3	58.7	2.8	2.8	n/a	100	4,097
Gambia	7.3	12	44.6	55.4	40.6	0	n/a	64.3	325
Ghana	5.6	8.4	41	59	18.5	n/a	0	100	212
Guinea	5.8	4.8	15.5	84.5	9.5	1.4	0	99.5	330
Guinea-Bissau	6.3	8.5	48.2	51.8	35.9	0.1	0	100	191

Kenya	4.9	8.4	44	56	16.4	9.2	6.9	80	336
Lesotho	6.2	10.9	84.9	15.1	20.8	0	n/a	7	375
Madagascar	2.1	8	55	45	32.2	n/a	11.2	88.8	252
Malawi	9.8	9.7	41.1	58.9	37.6	0	1.7	42.6	154
Mali	4.5	9	50.8	49.2	18.2	27.7	0	88.8	223
Mauritania	3.9	10.1	74.2	25.8	3.3	0	0	100	313
Mauritius	2.9	8.3	76.9	23.1	1.8	7.2	0	100	3,638
Mozambique	5.8	19.9	71	29	39.3	0	0.6	36.5	219
Namibia	6.7	12.9	70.1	29.9	5.2	1.5	74.8	20.5	1,516
Niger	4	10	50.8	49.2	37.7	2.9	5.4	94.6	172
Nigeria	4.7	3.3	25.6	74.4	6.1	0	6.7	90.4	317
Rwanda	5.5	13.4	57.2	42.8	32.8	0.6	0.3	65.2	218
Senegal	5.1	11.2	45.2	54.8	16.9	14	3.5	96.5	454
Seychelles	5.2	6.6	74.3	25.7	7.5	5	0	60.4	7,017
Sierra Leone	2.9	6.8	60.3	39.7	16.5	0	0	100	126
Somalia	2.6	4.2	44.6	55.4	0	0	0	100	
South Africa	8.7	10.7	40.6	59.4	0.3	3.8	77.7	20.9	2,860
Sudan	4.9	6.3	20.7	79.3	2.6	0	0	99.5	415
Swaziland	6	10.9	59.5	40.5	3.5	0	20	41.7	1,254
Togo	10.5	7.8	10.8	89.2	4.7	14.4	2.3	93.4	260
Uganda	7.4	9.1	27.9	72.1	28.8	0	0.2	52.3	284
United Republic of Tanzania	4.9	14.9	54.8	45.2	26.9	2.7	4.4	82.5	
Zambia	5.8	11.3	52.9	47.1	18.6	0	0	75.3	336
Zimbabwe	8.5	12.2	51.6	48.4	2.5	0	38.8	47.3	536

Sources: WHO NHA database and IMF economic indicator database

APPENDIX C: CASE STUDY OF AFRICAN COUNTRIES THAT HAVE REACHED HIPC COMPLETION POINT

A crude review of indicators in the health sector (Table C1) shows that immunisation levels, which are a good indicator of activity in primary health care, are either static as in the Ethiopian case, slightly decreasing as in the Ghanaian case, or are increasing as for Uganda and Mozambique.

Table C1: Immunization, measles (% of children ages 12-23 months)

HIPC Country	2000	2001	2002	2003
Ethiopia	52	52	52	52
Ghana	84	81	81	80
Mozambique	71	74	77	77
Uganda	61	63	77	82

Source World Bank Development Indicators (2005)

A more detailed analysis at country level is required and the following analyses of social spending uses country PRSP progress reports to analyse the extent to which social expenditure is increasing or planned to increase, and in which specific sectors.

Social Spending in Ethiopia

Table C2 shows the actual (2001/02) and estimated (2002/03) increase in poverty targeted spending in Ethiopia and also gives a break-down by social sector. Poverty targeted spending rose significantly as a percentage of GDP in 2001/02 but rose at a much lower rate in 2002/03. Health sector spending shows the same pattern, a dramatic increase over 2001/02 and a much less dramatic increase over 2002/03.

Table C2: Increase in Poverty - Targeted Spending and HIPC Debt Relief since the Decision Point
(In millions of US Dollars Unless otherwise Indicated)

	20001/02 Act.	2002/03 Est.	Total
Increase in poverty-targeted spending	138	121	259
(in percentage of GDP)	2.8	0.5	3.3
(in percentage of total spending)	6.7	5.1	11.8
Current poverty-targeted spending	44	67	111
Agriculture and natural resources	5	6	11
Roads	2	2	5
Education	31	58	89
Health	6	1	7
Capital poverty targeted spending	94	54	148
HIPC debt relief	50	62	112
(in percent of GDP)	0.8	0.9	1.7
(in percent of total spending)	2.4	2.6	5

Source: IMF (2004) Ethiopia – E-HIPC Completion Point Document pp7

Social Spending in Ghana

Poverty related expenditure in Ghana is showing a steady increase over the period projected period 2001-2004. Increases in basic education are significantly higher than increases in primary health care expenditure. Expenditure on health care is only growing at a marginal rate.

Table C3: Ghana: Poverty Related Expenditure, 2001 – 2004
(In percent of GDP, unless otherwise Specified)

	2001 Act.	2002 Est.	2003 Prov.	2004 Proj.
Total poverty related expenditure	4.5	4.8	6.5	6.9
(As a percentage of total government expenditure)	13.9	18.3	22.3	24.5
Basic education	2.8	2.8	3.6	3.3
Primary health care	0.7	0.6	1	1.5
Agriculture-poverty focused	0.1	0.2	0.2	0.2
Rural water	0	0.1	0.1	0.2
Feeder roads	0.2	0.3	0.5	0.4
Rural electricity	0	0.1	0.1	0.2
Other poverty-related expenditure	0.6	0.7	1.2	1
HIPC Relief not yet allocated	0	0	0	0.1
Memorandum items:				
HIPC Relief 1/	...	1.2	1.4	2
Total government expenditure (billions of cedis)	12,451	12,753	19,157	22,307
Nominal GDP	38,071	48,862	66,158	78,650

Sources: Ghanaian authorities; and fund staff estimates and projections

1/ Excluding 20 percent of relief that is allocated to domestic debt reduction

Source: IMF (2004) Ghana - E-HIPC Completion Point Document pp 10

Social Spending In Mozambique

Mozambique's spending on health and education has been growing steadily over the period 1998-2000 (Table C4). Actual health spending has been growing at a significantly higher rate than education spending despite the budgeted figures.

Table C4: Current Planned and Actual Expenditures in the Social Sectors 1998-2000
(In Units Indicated)

	1998	1999	2000	1998	1999	2000
	% of total spending budgeted			% of total spending actual		
Education	16.1	18.9	23.3	18.1	20.6	23.6
Health	7.7	9.9	12.4	7.1	9.0	10.1
Total health and education	24.6	28.7	35.7	25.2	29.6	33.7
Memorandum items:						
Total current spending (Mt billions)	4.651	5.699	8.116	5.268	6.321	7.836
Total current spending (US\$ mn)	392	449	535	445	498	516
Current health and Education (US\$ mn)	96	129	191	112	147	174

Source: IMF (2001) Mozambique Completion Point Document for E-HIPC pp 10

Social Spending In Uganda

Social spending in Uganda has also increased over the period 2000-2003, again with a greater focus on education expenditure than health expenditure. In absolute terms education is consistently approximately 4 times greater than health expenditure.

Table C5: Sectoral Allocation of the Budget, FY 2000/01 – 2002/03

	FY 2000/02		FY 2001/02		FY 2002/03		Growth
Sector	Shs Bn	% of total	Shs Bn	% of total	Shs Bn	% of total	%
Security	209.8	13.9	229.2	12	261.7	12.9	24.7
Roads	138	9.2	170.2	8.9	150.5	7.4	9
Agriculture	24.1	1.6	49.1	2.6	46.8	2.3	93.9
Education	403.8	26.8	458.3	24.1	505.2	24.8	25.1
Health	114.2	7.6	170.1	8.9	196	9.6	71.6
Water	36.4	2.4	54	2.8	48.7	2.4	34
Law and order	94.5	6.3	128.5	6.8	142.2	7	50.5
Accountability	17.1	1.1	22.8	1.2	26.6	1.3	55.8
EF and SS	95.4	6.3	139.9	7.4	149.7	7.4	56.9
Public Administration	264.9	17.6	325.3	17.1	361.2	17.8	36.8
Interest Payments	107.1	7.1	155.1	8.2	144.6	7.1	35

Source: IMF (2003) Uganda Poverty Reduction Strategy Paper Annual Progress Report pp24

EF = Economic Functions, SS = Social Services

APPENDIX D: Examples of community-based health insurance schemes

Health insurance function	Bwamanda DRC	Nkoranza Ghana	CAM Burundi	Health Care Fund Tanzania (rural)
Revenue collection	<ul style="list-style-type: none"> • Voluntary • Community rated • Collected during crop selling (usually March) • Annual contribution 	<ul style="list-style-type: none"> • Voluntary • Community rated • Collected Dec-Jan • Annual contribution 	<ul style="list-style-type: none"> • Voluntary • Contributions set by central government • Per family rate (2 adults & all dependent children) • Annual contribution 	<ul style="list-style-type: none"> • Voluntary, except for local government civil servants • Flat rate premium per household (no limit) • Exemption mechanism for poor • Annual contribution
Pooling and risk sharing	<ul style="list-style-type: none"> • Families 	<ul style="list-style-type: none"> • Entire families • Doctor determines access to benefits 		<ul style="list-style-type: none"> • Entire families
Purchasing & provision	<ul style="list-style-type: none"> • Linked to local hospital • All inpatient care and chronic care in health centre • 20% co-payment for hospital admission 	<ul style="list-style-type: none"> • Contract with NGO (mission) hospital • Covers admission/ inpatient care costs and reimburses costs of referral • Fee-for-service 	<ul style="list-style-type: none"> • Public health facilities only • All care at clinics & hospitals 	<ul style="list-style-type: none"> • Public health facilities • Out-patient services • Need to register with a specific facility and obtain care at that facility
Ownership, management	<ul style="list-style-type: none"> • Managed by district health team 	<ul style="list-style-type: none"> • Hospital based (mission) • No community involvement 	<ul style="list-style-type: none"> • Government initiated • Local government 	<ul style="list-style-type: none"> • Government initiated • District CHF board, community participation
% population covered & membership numbers	60-70% 20,000	23-27% 23,000	20-25% 1.2 million	5% in sampled districts
Cost recovery	65-70% non-personnel recurrent	55% of the cost of care for insured inpatients	34% of outpatient drug costs	

Sources: (Jakab and Krishnan, 2004, Arhin-Tenkorang, 2004)

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